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ABSTRACT

The study of medical practice plans describes the structural and operational characteristics of over 60 plans in U.S. medical schools. A documented description of the way the respective clinical faculties conduct their patient care activities is included. The study further establishes a typology based on plan structure and classifies the plans accordingly. The report includes an annotated bibliography on the subject of practice plans; profile matrices, for public and private institutions, displaying plan features relating to structure and governance, mechanics of administration, compensation patterns, income flow and disposition; a rationale for categorizing practice plans, and the actual classification of all plans reviewed; a set of flow diagrams, illustrating for each basic type of plan the source and distribution of all practice plan income; and a discussion of the study's findings and trends since the 1950s. This report covers only the first year of a two-year study. (JMF)

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# MEDICAL PRACTICE PLANS AT U.S. MEDICAL SCHOOLS

## A REVIEW OF CURRENT CHARACTERISTICS AND TRENDS

VOLUME I

INTERIM FINAL REPORT

**Association of American Medical Colleges**

One Dupont Circle, N.W., Washington, DC 20036

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# MEDICAL PRACTICE PLANS AT U.S. MEDICAL SCHOOLS

## A Review of Current Characteristics and Trends

William C. Hilles
Sharon K. Fagan

VOLUME I

INTERIM FINAL REPORT

This Interim Final Report is in partial fulfillment of work to be performed and is subject to modification.

Division of Operational Studies
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

March 1977

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## EXECUTIVE SUMMARY

The Study of Medical Practice Plans describes the structural and operational characteristics of over sixty plans in U.S. medical schools. These plans were found to include a documented description of the way the respective clinical faculties conduct their patient care activities. The study further establishes a typology based on plan structure and classifies the plans accordingly. Significant trends are observed and reported.

The study's objective was to undertake a nationwide review of all medical school practice arrangements, and to describe their primary features. Thus, the effort was intended to result in current, comprehensive knowledge of the subject. Medical schools developing a plan for the first time, or preparing to alter their existing plan, would have the outcome of this study as a ready reference work.

Using AAMC's collection of articles, monographs, and written descriptions of practice plans, supplemented by telephone, written or direct inquiry of the schools where information was lacking, the following products were generated:

(1) An annotated bibliography on the subject of practice plans.

(2) Profile matrices, for public and private institutions, displaying plan features relating to structure and governance, mechanics of administration, compensation patterns, income flow and disposition.

(3) A rationale for categorizing practice plans, and the actual classification of all plans reviewed.

(4) A set of flow diagrams, illustrating for each basic type of plan (representing at least one public and one private institution) the source and distribution of all practice plan income. Since compensation is the most significant object of expense from plan income, the deviation of the various components of compensation is highlighted.

(5) A discussion of the study's findings and trends since the 1950's.

The study's findings were determined from review of the completed profile matrices. Following is a recap of the more striking disclosures:

- More than half of all the medical schools in the country have a written practice plan which applies universally throughout the institution; a dozen or so have separately incorporated plans.
- Over three-fourths of the plans have either been initially implemented or significantly revised since 1970.
- In all but a handful of plans membership is required for clinical practitioners who are full-time faculty.
- Fewer than a dozen institutions do not have a structured, broadly representative governing body provided exclusively for their plans; in more than half of all the plans reviewed, the dean is a member of this body.
- Close to 60% of the plans have full-time, discrete plan managers.
- Over 40% of the institutions whose plans are included in this study provided data as to source of direct payment for patient services.
- Sixty percent of the plans centrally bill and collect above the departmental, or individual level; fewer than a dozen plans utilize an outside service bureau.
- In only rare instances is any patient-generated income excluded from a plan's purview.
- Fewer than a dozen plans do not have a system of employment agreements or contracts between the plan participant and the institution.
- Close to two-thirds of the plans include a personal incentive component of compensation.

- Malpractice insurance is usually institutionally financed either by the plan or parent institution; over a dozen have implemented selfinsurance programs and over thirty-five are considering the arrangement.

A number of significant trends are readily apparent when comparing the findings of this study with two milestone studies conducted since mid-century, and when reviewing financial data provided to the AAMC by the medical schools annually. Income generated by practice plans as used by the schools to support their general operations has increased dramatically, not only in dollar amounts but also in the proportion of this source to regular operating revenue. Further trends discussed in this report relate to such matters as the increasing incidence of geographic vs. strict full-time faculty appointments; the growing prevalence of centralized and discrete management, including fee handling; and the preference for monetary rather than time controls over practice activity.

## INTRODUCTION

In recent years, more and more U.S. medical schools have developed formal policies and procedures governing the manner in which faculty physicians provide services to patients, reimbursement is secured, and the resulting funds are utilized. For a number of reasons, the development of these medical practice plans is continuing, and there is a great need for information to assist medical school administrators who are developing new plans or altering existing plans. It is also important to secure a better understanding of the current organization of medical practice in the academic setting, for the benefit of those at all levels in public and private sectors who need to assess the potential impact on academic medicine of proposed changes in the health care delivery system. For these reasons the Association of American Medical Colleges with support from the Bureau of Health Manpower, began a formal, two-year study of medical practice plans in January 1, 1976. This is the report of the first year of this study, describing general characteristics of plans and trends in plan development, based on a nationwide review.

The second year of the study will include an in-depth examination of at least one institution representative of each of the more commonly used types of plans.

### Historical Background

Sweeping changes have occurred since mid-century in the way medical care is delivered and paid for. These changes have had profound effects at the interface between patient service and education in U.S. medical schools and centers. A brief review of these historical developments will aid one in understanding why medical practice plans were developed and the forms they take.

Until mid-century, medical schools depended more heavily on volunteer and part-time paid faculty for teaching in clinical subjects. The nucleus of full-time teaching clinicians was small, if it existed at all. The schools relied extensively upon indigent patients admitted to the wards of their teaching hospitals for clinical instruction. The clinical faculty payroll was relatively small, and there was no payment for most of the patient service.

A number of social and economic forces led to increases in the number of full-time clinical faculty. As a result of the Flexner Report, medical schools had moved towards closer ties with their universities and had begun to emulate other parts of the institution that had full-time faculties. The increasing demands for medical care placed heavy burdens on the voluntary clinical faculty and they could no longer devote the necessary time and energy to teaching as they had in the past. The response of the medical schools to federal initiatives to increase the level of biomedical research led to an expansion of full-time faculty with the proper preparation and time to undertake investigative work. The growth of undergraduate and graduate medical education enrollments and the acceleration of specialization required larger clinical faculties for which the medical schools found increasing difficulty in providing support from university resources.

At the same time the clinical faculty size was increasing, the demand for quality care as a public right led to a rather sudden recognition of a governmental role in paying for such care. The Social Security Amendments of 1965 provided health insurance for the aged and disabled (Medicare) and grants to the states for medical assistance to the economically disadvantaged (Medicaid). Together with the rise in private medical insurance, Medicare and Medicaid changed the system of financing medical care of the indigent, putting them essentially on the same, fee-for-service basis as other patients. As a result, the private and semiprivate services of the teaching hospitals have largely been integrated into the teaching programs, and greater direct faculty involvement in the care of these patients is required.

Thus, the patient service activities of the greatly increased numbers of clinical faculty members must be financed, and third-party reimbursement for physician fees are available for this purpose. To maintain control of faculty compensation, however, and to maintain a balance of faculty activities, medical schools have felt a need to centralize and control this income and its utilization. To meet these needs, medical practice plans have been developed at a rapid rate.

## Recent Developments

During the past three or four years national interest in medical practice plans has intensified. Witness to this is the fact that more than two-thirds of the plans reviewed in this study began or have undergone major revision since 1972. Some of the impetus for this heightened interest has been the growing availability of third-party reimbursement for patient service provided by medical school faculty. But a more important factor has been the changing picture with respect to medical school financial resources. Although the degree of shift varies from school to school, there has been a diminution of the growth of federal support to the medical schools, forcing a concurrent demand for funds from unrestricted sources. Reduced proportional federal support for biomedical research has been particularly striking. Fortunately, much of the slack has been covered from discretionary resources. Prominent among such sources has been income from medical practice plans, which provides vital support for medical school faculty compensation. In order to keep the salaries of medical school faculty members competitive with the earnings generated by their counterparts in private practice, schools have written and rewritten practice plans to reflect more liberal personal incentives.

As federal, state and local governments increased appropriations to the health services sector, so grew the demand for greater accountability for costs incurred by providers. Medical schools, in particular, have been under close scrutiny in this regard, and in some quarters have found it to their advantage to encourage group practice on the part of their faculty. The result has often been a more rational and efficient use of health resources so that a better return can be achieved for time spent in practice, in dollars, in quality of care, and in faculty and patient satisfaction.

Against this background, the Association embarked on this study to review the current state of the art of medical practice plans.

## Other Work on Medical Practice Plans

The Association of American Medical Colleges has maintained an interest in the evolution of medical practice plans for many years. Two decades ago this began with a comprehensive, detailed

study by the late Augustus Carroll of the policies and practices relating to the patient care activities of the faculty at nineteen medical schools[1] Since then, the Association has collected intermittently in varying detail information on the administration of faculty compensation and on the derivation of income through plans for medical practice. In addition, medical school business officers both nationally and regionally have participated in and profited from discussion and workshops on the subject of practice plans.

Prior to Carroll's research in the late 1950's, there had been little reference in the literature to medical practice plans, either as a described arrangement or as a source of medical school income. Drs. John Deitrick and Robert Berson however, did publish a book in 1953 which discussed in detail the financing of medical schools as well as faculty appointment practices.[2] The two authors do provide good historical background for the setting in which formal practice plans began to appear.

During the 1960's, Clyde T. Hardy, Jr. of the Bowman Gray School of Medicine became interested in documenting the characteristics of practice plans nationwide. In 1967 in cooperation with the AAMC he surveyed 84 institutional members of the Association, and received 72 replies. The results were published by the AAMC.[3]

An additional source has been used in this study of practice plans and sheds considerable light on the growth of income to the medical schools from this source. Since 1956-57, the AAMC has gathered annual data from its constituents on their expenditures and sources of support for meeting them. Income from medical service plans has been reported along with other financial data each year in the Journal of the American Medical Association's medical education issue.

Other materials used in this study are referenced as footnotes where appropriate and appear in the Bibliography.

## SCOPE AND OBJECTIVES

There are currently 111 established M.D. degree-granting accredited medical schools. Participation in Phase I of the Study was encouraged by open invitation from the AAMC. Limits on the time available to synthesize and document plan descriptions precluded inclusion of more than the 67 institutions represented in this report. Another group of 32 schools have either implemented or are developing guidelines for implementation of a medical practice plan. Twelve schools of medicine do not have an acknowledged practice plan that is institutional in scope.

It has been the general objective of this two-year study to identify and describe the key characteristics of the plans found to be functioning nationwide. The descriptive analysis which follows addresses structure and governance, mechanics of administration, compensation patterns, income flow and disposition. Additional objectives have included (1) a review of national trends with respect to practice plans; (2) the development of a rationale for typing plans and for grouping them accordingly; and (3) an in-depth examination of at least one institution representative of each of the more commonly used types of plans, such examination to be conducted on site to review any problems of implementation and operation and to determine how it is evaluated by the school's faculty and staff. This latter objective will be undertaken during the second year of the study.

The end result of this two-year study will be an updated and broadened knowledge of the subject of medical practice plans. Medical schools planning to develop a new plan for the first time, or preparing to alter their present plan, will have the outcome of this study as a ready reference work.

## METHODOLOGY

### Collection of Plans

Over the years the AAMC has collected intermittently and in varying detail information on the administration of faculty compensation through plans for medical practice. First, steps were taken to determine through contacts with the schools whether the plans the Association had in its files were current; where they were found to be no longer valid, updated versions were gathered for analysis.

### Profile Matrix

A comprehensive set of matrices displaying a number of characteristics for each plan was generated for this study. This was developed in the following fashion:

(1) Drawing from written plans sent to the Association by the medical schools, project staff developed an internal checklist (See Appendix A) to record consistently the major characteristics of practice plans. Topics under which questions were posed included: plan organization, membership requirements, governance, administration, practice setting, fee determination and collection, compensation and income distribution patterns, malpractice liability insurance, plan objectives and implementation procedures. Some of the data on the checklist were completed by staff with information on hand; when data were not immediately available, it was gathered by telephone or by site visit.

(2) An abbreviated instrument was developed in matrix fashion (See Appendix B) to display what was judged to be the more salient features of practice plans. The completed checklists were used as source documents for filling out the preliminary matrices.

(3) Both checklist and the preliminary matrices were then sent to the deans of all medical schools under review to validate the analysis and to gain approval to use the data in the study (See Appendix C).

(4) The final matrices were completed for each responding school, and constitute a major section

of this report. Very few schools wished their identity known on the matrices; therefore, the institutional entries have been letter-coded, but with a regional designation. They are further disaggregated by private and public status.

Practice Plan Typology and Grouping

From information displayed on the checklist and profile matrices, a typology was developed for grouping plans with similar features. Earlier work in typing practice plans (i.e. Rand Corporation, Institute of Medicine) was reviewed but rejected for the reasons detailed later in this report. The AAMC typology, in brief, reasons that plan structure should be the criteria for classification. A spectrum can be drawn where centralized, more formally structured plans appear at one end, while the more decentralized, less structured, plans appear at the other extreme. Using the typological framework, plans were assigned to one of three categories, further broken down by private and public ownership.

Income Flow Diagrams

Following the assignment of plans to the appropriate category, at least two plans (one public, one private) were selected for further review as to income generation and disposition. A dynamics model, or flow diagram, was drawn for each selected plan. Each diagram depicts gross plan income. The models further illustrate sequentially the distribution and use of the revenue by object of expense. Special attention is paid to the various components of faculty compensation (i.e. base salary, fringe benefits, salary supplements and/or incentive payments) and the sources of these increments. A brief description appears opposite each flow diagram.

Use of Other Data

As each institutional plan was reviewed, the study's staff drew upon other AAMC data relating to the particular institution and its practice arrangements. Such data already in Association files included accreditation reports, faculty salary questionnaires, and various correspondence with the schools on the subject. The use of these materials served to provide insight into aspects not otherwise obvious in the written plan.

## RESULTS AND DISCUSSION

### Plan Characteristics

In the following sections, characteristics of medical practice plans in operation at U.S. medical schools are described. A typology is developed, and examples of each type are presented. Finally, a discussion of trends in practice plan development is presented.

The following observations have been made using a set of matrices which record the more salient characteristics of medical practice plans. These matrices are presented separately for public and private institutions and can be found in Volume II.

The development and growth of plans for medical practice at academic institutions has accelerated during the last sixteen-year period. Seventy percent of those plans currently in existence have been implemented since 1960. Very few plans now in operation have continued to function without major revision. Ninety percent of the public medical school plans described in this study have been revised since 1970. A large proportion, 75 percent, of private medical school plans have also been significantly modified.

The AAMC Study of Medical Practice Plans includes descriptions of a variety of organizational structures. Most of the medical schools participating in this study report having a single practice plan that is fully institutional in scope. In most cases the location of a comprehensive centralized plan is within the school of medicine. Variation of clinical practice arrangements for academic departments or medical specialties is permitted by nearly one-third of the institutions in this report. In these instances, the departments are given considerable latitude in customizing a plan to their needs. Over 20 percent of the public medical schools have practice plans which are separately incorporated.

Membership in a public medical school practice plan is required for full-time clinical faculty in almost every case (95%). A little more flexibility in membership requirements seems to prevail at private medical schools (80%). In approximately 10 percent of all practice plans, part-time and volunteer faculty are eligible to participate fully in the plan with some schools requiring the participation of

such faculty. More than one category of membership is available in 20 percent of the plans studied. Usually "other" types of plan membership are optional for faculty who are less than full-time at the medical school.

A written description of the practice plan structure and its operational ground rules has been prepared and formally approved at most of the institutions included in this study. Plan policies are frequently determined by a group of individuals whose primary objective is the resolution of clinical practice-related issues. The composition of this body always includes faculty representatives from the clinical science disciplines. A common mixture of some clinicians elected at large in addition to each clinical science department chairman is frequently observed. Deans participate in these deliberations at 80 percent of the public medical schools and more than half the private institutions. Other university, state and hospital officials are involved with practice plan governance at the same rate, (65%), for both public and private medical schools. Basic science faculty in private institutions are unlikely to be members of a practice plan policy-making body, but some official representation from the basic sciences is visible at one-quarter of the public medical schools.

The administration of medical practice plans has been evolving into a full-time occupation. Seventy percent of the public medical schools and 43 percent of the private medical schools studied report that a full-time manager is responsible for plan operation. Nearly half of these administrators report directly to a health center or university official other than the medical school dean. When administrative staff of the medical school is involved part-time in the coordination of plan support services, the dean usually assumes greater responsibility for practice plan operation. This situation occurs more often in private medical schools than in public ones.

Sites for the provision of services by plan participants vary little from one medical school to another. Most faculty physician offices are located within the school and its owned or affiliated hospitals. Occasionally office space is leased in a facility outside the institution. There is not much difference between public and private schools in the kinds of clinical activities included within the plan purview. Hospital inpatient services are under the plan umbrella in at least 90 percent of the cases studied. Eighty-three percent of the plans encompass hospital outpatient departments. Physician practice in ambulatory clinics outside the hospital is also included in 70 percent

of the plans.

Seldom are any patient-related income generating activities by participants in a medical practice plan excluded from the plan. Several mechanisms for monitoring faculty practice activities are in effect at most medical schools, including employment agreements, required financial statements and central billing and fee collection procedures.

The centralization of billing and collection services for patient fees has been located most often in the office of a full-time plan manager. Uniform procedures may also be adopted at decentralized points, e.g. departments, and only the methods of implementation vary. Initial disbursement of professional fees received is also frequently a function of the practice plan office. Indeed a definite pattern of centralized plan operation emerges based on the observation that 79 percent of the public medical school full-time plan managers and 60 percent of the full-time plan managers at private schools are responsible for a professional fee billing, collection and disbursement system.

Few practice plans have effected for ambulatory patients a unified billing system which includes hospital charges. Approximately one-third of all plan billing systems provide for billing 100 percent of the fee schedule. A majority of those which do are centralized in a plan office. The average number of monthly statements sent on behalf of plan participants ranges from 4,400-40,000 at public medical schools and from 5,000-68,000 at private schools of medicine. Net collection rates for the two groups are remarkably similar, 70-97 percent by public medical school plans and 79-98 percent by private medical school plans. Analysis of plan income by source of direct payment for patient service is handicapped by the general unavailability of supporting data. Many more public medical school plans (63 percent vs. 39 percent of private medical school plans) are equipped to generate statistical indicators of patient service loads and collection experience.

The Internal Revenue Service review and approval of the tax status for a medical practice plan can be either separate or included in the audit for the parent organization within which the plan operates. Forty-three percent of the plans in effect at public medical schools have received IRS approval; one in four practice plans at

private schools have been approved. Half of these reviews by the IRS have occured since 1970.

A direct relationship between faculty involvement (percent of time spent in major areas of activity) and sources of faculty compensation has been identified at 40 percent of the public medical schools having a plan(s) for medical practice. Fifty-two percent of the private medical school plans evaluate this relationship. A common mechanism for relating faculty activities to sources of compensation is effort or time analysis. A less formal but frequently used alternative is the annual budget review by department chairmen and the medical school dean.

Although plan participants usually receive an employment agreement upon appointment to the medical school faculty, separate components of compensation are not usually identified. A formula describing the derivation of base, supplement and incentive portions of compensation is often presented to faculty in conjunction with a letter of appointment. Sixty-three percent of the public medical school plans in operation provide an incentive component of compensation for participants. Seventy percent of the private medical school plans offer opportunity to earn incentive income. In most cases the amount of incentive income is affected by the level of medical practice activity. Salary ranges for full-time faculty positions held by plan participants are specified by 50 percent of the public institutions (either medical school or parent) and 43 percent of those privately supported.

Fringe benefits which are usually available to practice plan participants include disability insurance, health insurance, life insurance, tax sheltered annuities and other plans for retirement. Clearly a majority of these benefits are provided by the institution. The benefits most frequently supplemented by practice plans are as follows: disability insurance by 30 percent of the public school plans and 22 percent of the private ones; life insurance by 28 percent of the public school plans and 17 percent of the private school plans; retirement plans by 45 percent of public school plans and 22 percent at the private school plans.

Although medical practice plans are only occasionally exclusive providers of customary fringe benefits, they have become responsible for payment of malpractice liability insurance premiums at 53 percent of the public medical schools and 26 percent of the private schools of medicine included in this study. Public schools of medicine also cite departments (25% of the cases) and parent universities

(20% of the cases) as sources of premium payment. Private medical schools report that hospitals (30% of the cases) and individuals (30% of the cases) are alternative premium payment sources. Frequently coverage is purchased by more than one agent. In 40 percent of all cases the university holds a blanket policy. Individuals are the policy holders in almost 30 percent of the study schools. Practice plans and hospitals account for the remainder of the policy holders.

Rapid escalation of premiums for malpractice liability coverage by commercial carriers has motivated 53 percent of the public medical schools and 65 percent of the private institutions to consider self-insurance schemes. An additional 20 percent of the public schools of medicine and 22 percent of the private schools have recently implemented some type of mechanism to insure themselves for malpractice liability. In these instances, the plan or the institution usually pays the premiums.

In general the evolution of a plan(s) for medical practice is a combination of many changes in the external and internal environment.

Typology of Medical Practice Plans

Some attempts have been made over the years to classify medical practice plans according to a logical typology. This has posed real problems since plans have become very complex arrangements, often uniquely patterned to fit the local needs of a particular institution. The characteristics of practice plans as set forth in the institutions' written documents cover a wide variety of policy and procedural areas -- governance, restrictions (or lack thereof) as to practice setting, membership requirements, administrative and reporting procedures, fee determination, billing and collecting practices, compensation patterns, income distribution, and general expenditure-approving authorities. To classify plans consistently into a neat grouping which considers all these attributes is difficult or even impossible.

A.P. Williams of the Rand Corporation attempted to classify practice plans following a review of the arrangements at a sample of ten medical centers.* He found no two plans the same, but presented three prototypic plans based on the salient features of financial incentives for the individual physician, control by the dean and department head over physician compensation, and the basis for allocation of an individual's earnings to funds under the control of the department head and the dean.

* A. P. Williams, "The Resource Allocation Process in Academic Health Centers", in preparation.

The three types presented by Williams were: Plan A, a departmental group with negotiated salary; Plan B, a departmental group with incentive; and Plan C, a private practice "income tax". The survey performed for the present study found plans similar in many respects to each of Plan A, Plan B and Plan C of Williams, but others were different from any one of the three. The three plans of Williams do not in fact include all existing combinations of the salient characteristics he identified. Careful study of his draft report shows that he intended the three diagrams to be illustrative examples rather than a comprehensive typology. There would be a typology only if one focused on the distinguishing features of negotiated salary, incentive, and private practice "income tax", because only in this way would the classification be exhaustive.

With data from sixty-seven centers rather than ten, it was even more difficult to find patterns, and the typology presented in this report is rather general, focusing on the organizational and certain operational characteristics of the plans rather than on control per se. With this more general approach, the attributes selected do tend to cluster together. A spectrum can be constructed which shows a centralized, more formal plan structure at one end, and a decentralized, less structured arrangement at the other. This axis is illustrated below:

Centralized (formal) Plans ←——— Intermediate ←——— Decentralized (informal) Plans

There are at least four aspects of a plan's organization and operations which can generally be identified with the three positions on this spectrum. These are considered on the accompanying illustration (See Table 1). As with most classification schemes when there are as many variations as there are in describing practice plans, some arrangements may not fall distinctly into a particular grouping for all characteristics considered; however, in general the patterns advanced above do hold.

T A B L E 1

MEDICAL PRACTICE PLAN TYPOLOGY

| PLAN FEATURES | TYPE A Centralized ← | TYPE B Intermediate ← | TYPE C Decentralized |
|---|---|---|---|
| Organization & Participation | | | |
| * Structure | A discretely recognized entity, either within or external to the medical school, having its own personnel, budget and procedural guidelines. | A common framework for clinical practice activity exists within which departmental or specially groups function. | A variety of clinical practice arrangements for academic departments or medical specialties are permitted. |
| * Policy Determination | All practicing clinicians are included and directly and/or indirectly through their representatives meet with institutional officials to focus only on clinical practice - related issues. | Most clinical disciplines are participants in deliberations about clinical practice - related issues identified by institutional officials. | Executive faculty and the dean consult as necessary during the routine conduct of general meetings. |
| Operations | | | |
| * Administration | A full-time manager supervises the day-to-day plan operation with responsibility for all administrative services supporting the practice of medicine. | A member of the dean's regular administrative staff is the locus for coordination of many plan support services. | Either the department head or his designate directs administrative support services. |
| * Fee Handling | All clinical practice related revenue flows through the Plan Office which renders bills, collects fees and disburses income. | Uniform procedures for billing, collection and disbursement of fees are implemented. | Options for billing, collection or disbursement of fees are available to academic departments or medical specialties. |
| Private Medical Schools | 12 | 10 | 3 |
| Public Medical Schools | 21 | 16 | 5 |

## Examples of Practice Plan Income Flow

At least two plans, one from a public and one from a private school, have been selected as examples of each of the types recorded above. Each is described as a model which diagrams the flow of income generated through the plan, and sequentially displays expenditures by object category. Particular attention is paid to the compensation expense item and the source of the various components of this item. A brief description appears on each diagram's facing page.

Generally, each block on the diagrams depicts practice plan distributions in the aggregate, namely for all faculty under the plan whether it be a schoolwide, departmental or sectional arrangement. Often, when the components of compensation are considered, however, the focus is on the individual and his/her earnings.

No rigorous attempt was made to standardize nomenclature in many of the blocks. The terminology used to describe a distribution point, or fund repository, was taken directly from the respective school's plan description without reinterpretation.

# INCOME FLOW DIAGRAMS

Practice Plan

Income Flow Diagram #1 (Type A)

(Private Medical School, South)

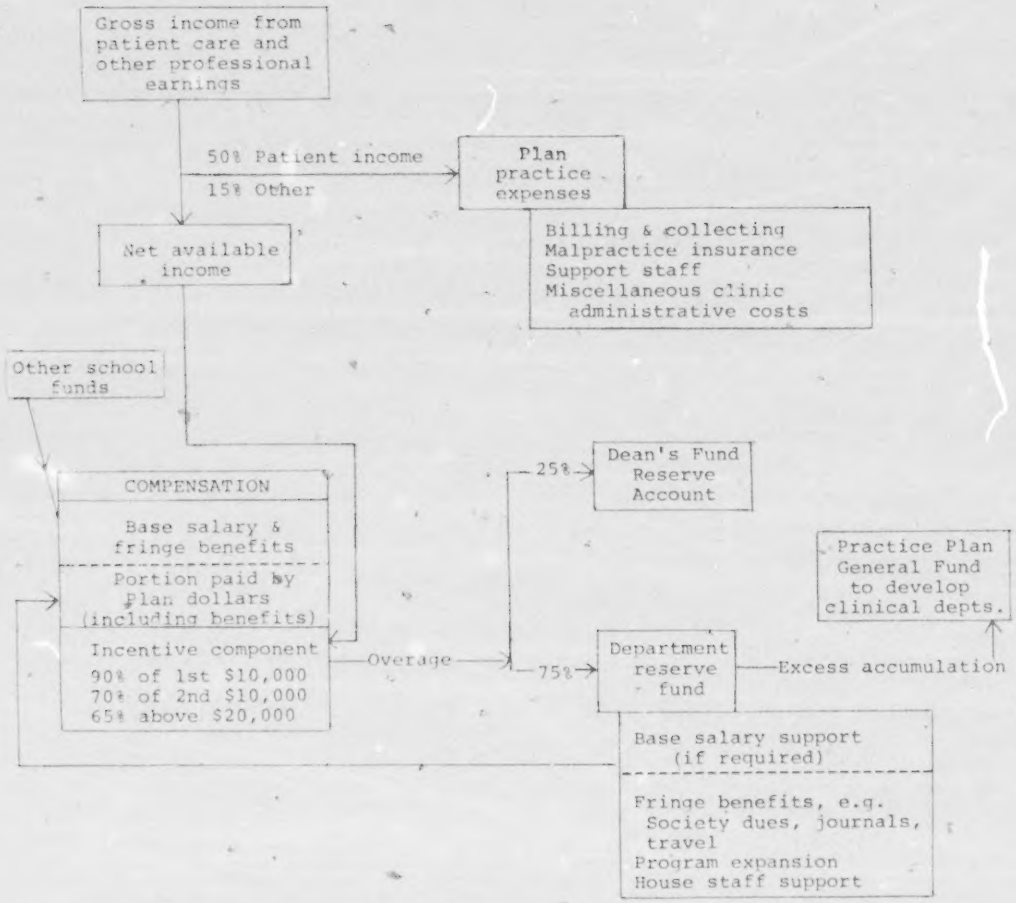
This centralized practice plan covers all full-time clinical faculty physicians. Practice earnings are generated both at a new University Hospital and at several affiliated hospitals. All income derived from professional activities must go into the plan, including practice earnings, honorariums, and royalties. The physician is paid a total salary from the medical school. This salary is negotiated with the clinical department chairman and dean who decide the mix of sources (grants, institution, and professional earnings) appropriate for the individual physician. The professional earnings component for each physician is influenced by the amount of revenues he generated in the preceding year.

Fifty percent of patient-related income and 15 percent of other professional earnings go to the medical school which uses it to cover the cost of practice expense, which includes nurses, auxiliary personnel, records, billing, appointments, central records, etc. Any earnings over a physician's projected contribution to his total salary are taxed, but are then distributed as an incentive. The physician gets 90 percent of the first $10,000, 70 percent of the next $10,000, and 65 percent after that. The remaining portion is divided between the dean's fund (25%) and department or section reserve funds (75%). Expenditures from the dean's fund are made at his discretion for new or operating school programs. The department reserve fund, administered by the department chairman and two elected faculty representatives, is used to defray a variety of departmental expenses. This fund is also used to make up deficits in salaries for those physicians who do not earn their projected amount, i.e. physician base salaries. Excess accumulation above 150% of total professional and fringe benefits costs paid to clinical faculty from Practice Plan sources are shifted to "Practice Plan General Fund" and used to develop clinical departments participating in the Plan. This account is administered by the Plan's Executive Committee and Medical Center Administration.

Practice Plan

Income Flow Diagram #1 (Type A)

(Private Medical School, South)



Practice Plan

Income Flow Diagram #2 (Type A)

(Public Medical School, Midwest)

The Plan at this public medical school typifies one where there is considerable central control and involvement at the school level. The Dean has strong administrative responsibility. All full-time faculty licensed to practice in the State and actually conducting patient care activities are required to participate in the Plan; non-physician faculty and part-time physician faculty may be nominated and appointed to Plan membership with the Dean's approval. Whether generated on-or-off-campus, all "professional income" of full-time faculty is considered Plan income when they are acting "in their capacity as Plan members". Where such activities result in pay for patient care or regularized administrative or consulting activities related significantly to but not directly involved in the provision of patient care, such income is included under the Plan.

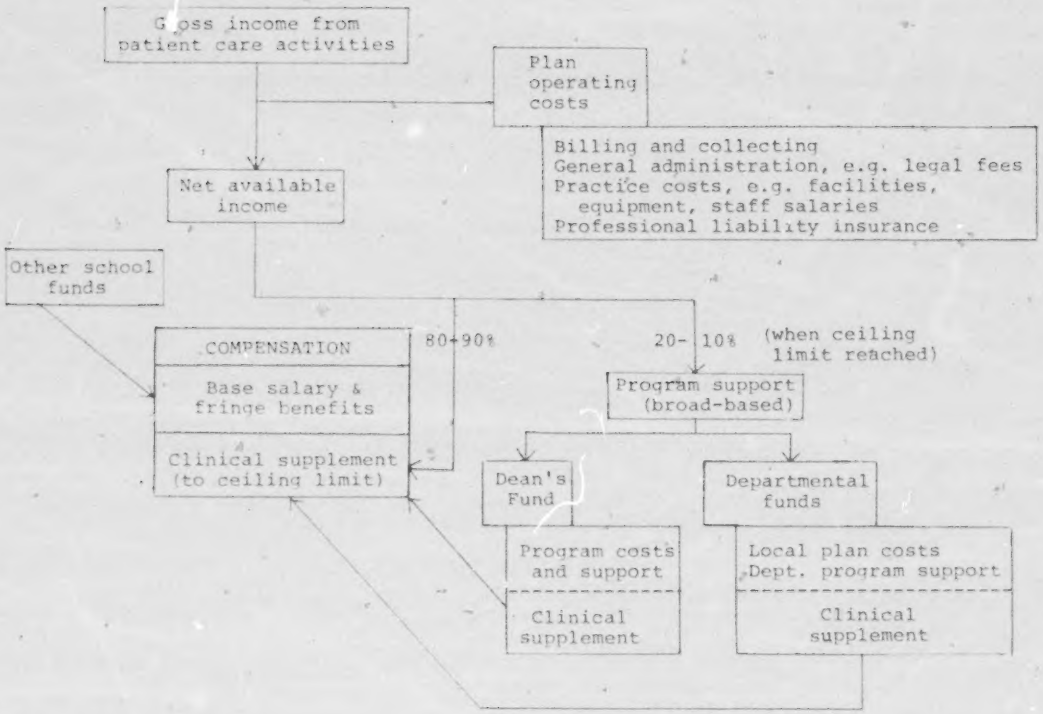
Annually each Plan member signs a "ceiling agreement" which includes a recommended base salary, usually derived from sources other than Plan revenue, and a clinical supplement. The latter is held within a range with a "ceiling limit" and derived from net available income. The combination of base and supplement is approved each year by the Dean and high authorities.

Gross income from patient care activities is reduced first by an assessment to cover the costs of operating the Plan. Included are not only administrative expenses, e.g. billing and collecting, but also professional expenses, e.g. professional liability insurance, facilities overhead, technical staff. Such expenditures are recovered monthly. The net residual is distributed in the following proportions: 1) normally at least 80% and no more than 90% to support the clinical supplement (where the net exceeds the individual's "ceiling limit" the excess is available for "program support" and with authorization may also be used to provide clinical supplementation up to the "ceiling" for those whose activities would minimize their earning potential); 2) normally at least 10% and no more than 20% to "program support". Program support can be used broadly for educational, research and service programs of the school, and where appropriate by their departments and sections. By prior agreement this accumulation is sub-allocated to a fund for use by the Dean (in consultation with Provost and the Plan's advisory committee), and to the respective department. A major use of both the departments' and the Dean's funds is to support clinical supplementation where required.

Practice Plan

Income Flow Diagram #2 (Type A)

(Public Medical School, Midwest)



Practice Plan

Income Flow Diagram #3 (Type B)

(Private Medical School, Northeast)

The Practice Plan at this small urban private medical school was implemented in June, 1976. Previously, there had been no plan; each clinical faculty member was entitled to his own practice earnings in addition to his University salary. The new Plan embraces a multidisciplinary association of single specialty groups each representative of a clinical department of the medical school. Each of the groups is free to choose the form of organization most suited to its needs. Membership includes: 1) All regular and "grandfathered" geographic full-time clinical faculty appointed at the time of the Plan's implementation; 2) strict full-time clinical faculty who elect to join; 3) part-time clinical faculty who elect to join and who do not maintain offices for practice outside the Health Sciences Center.

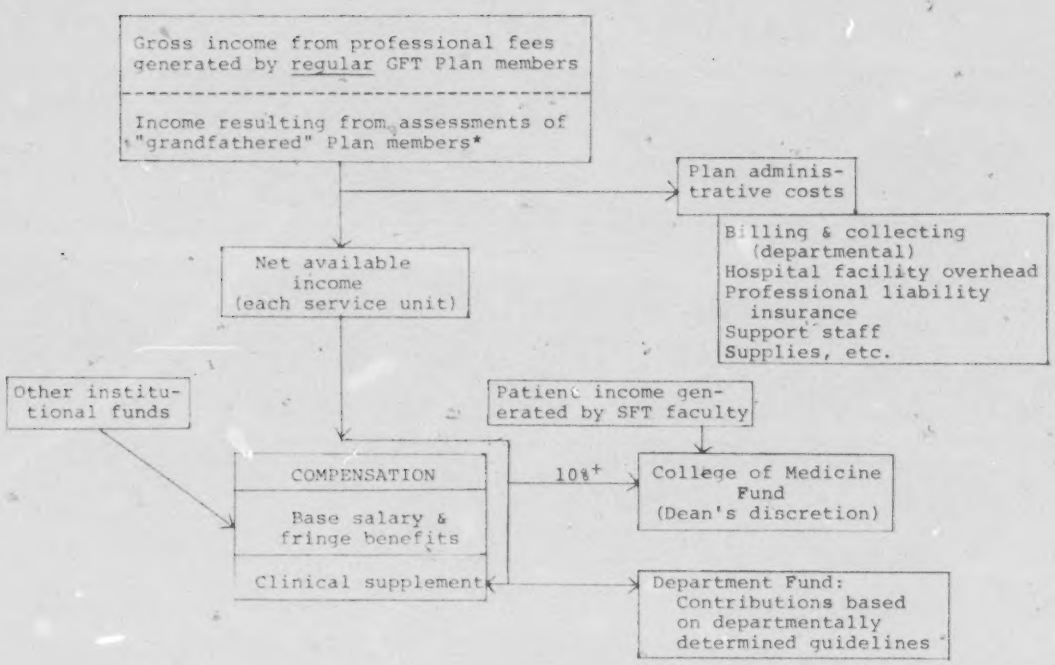
All gross income generated by the regular GFT clinical faculty is recorded in individual practitioner accounts following a departmentalized billing and collection process. "Grandfathered" members are assessed in accordance with guidelines developed and imposed by the Plans governing body. All patient income generated by SFT Plan members is deposited into a College of Medicine Fund to be disbursed at the Dean's discretion.

The first call on gross income generated by regular GFT and "grandfathered" faculty is support for Plan administration. This includes hospital overhead charges, annually negotiated on the basis of space utilization; computer service bureau costs prorated to the service units on a per statement basis; professional liability insurance; and other staff and non-personnel administrative costs. The next expense of the Plan is a minimum 10% contribution by each service unit to the College of Medicine Fund, to be used at the Dean's discretion. The residual is to be divided between the respective department and the earning practitioner in accordance with a departmental plan. Departments are encouraged to base their component on the practice activity of individuals, assuring that individuals who do not wish to practice are not forced to contribute to the departmental fund.

Practice Plan

Income Flow Diagram #3 (Type B)

(Private Medical School, Northeast)


Gross income from professional fees generated by regular GFT Plan members
Income resulting from assessments of "grandfathered" Plan members*
Plan administrative costs
Billing & collecting (departmental)
Hospital facility overhead
Professional liability insurance
Support staff
Supplies, etc.
Net available income (each service unit)
Other institutional funds
Patient income generated by SFT faculty
COMPENSATION
Base salary & fringe benefits
Clinical supplement
10%+
College of Medicine Fund (Dean's discretion)
Department Fund: Contributions based on departmentally determined guidelines

*"Grandfathered" Plan members are geographic full-time clinical faculty who at the time of the Plan's implementation had "proven financial, professional, or legal obligations outside the University setting" (prior to July 1, 1975). "Grandfathering" ordinarily applies to ambulatory care only.

Practice Plan

Income Flow Diagram #4 (Type B)

(Public Medical School, Northeast)

This practice plan provides a central administrative framework while preserving considerable departmental autonomy in determining the most effective distribution of its plan revenue. Practice takes place at a wide variety of affiliated hospitals and unaffiliated facilities. All full-time and part-time clinical faculty licensed to practice in the State are required to be members of the plan. A voting participant is one who spends 50% or more at the College Hospital or affiliates.

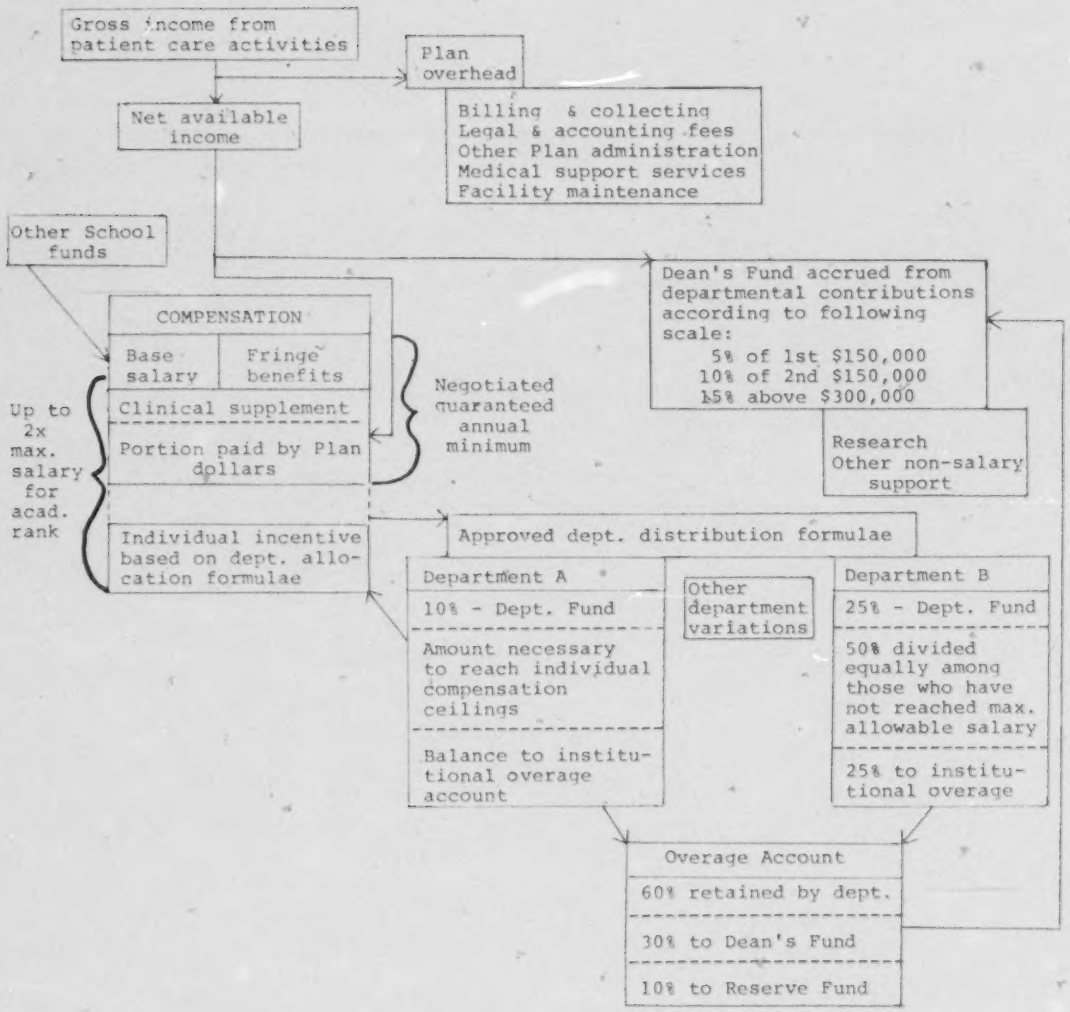
All patient-related income is deposited into the Plan. A minimal guaranteed salary is negotiated annually between the individual, the Department Chairman, and the Dean. This salary has two components: 1) an academic base which follows a schedule according to academic rank, and 2) a clinical salary component part or all of which may be provided from practice plan revenues according to departmental distribution formulae. Such formulae must be approved by the School's Board of Trustees. In no case, however, may the maximum allowable total compensation, excluding fringe benefits but including the clinical supplement, exceed twice the maximum academic base salary for a given rank.

An assessment is applied at the outset to gross revenue to support plan overhead. Such items as cost of billing and collecting, legal fees, medical support, and facility maintenance are covered by this charge. The next lien against the Plan's revenue is a progressive tax for the Dean's Fund. This is on the basis of departmental collections (net of overhead) at the following rate: 5% of the first $150,000, 10% of the second $150,000, and 15% of the net above $300,000. Although each department has its own distribution formula, there is an overriding obligation to assist each departmental practitioner to reach his/her allowable maximum salary. Invariably there is a percentage retained for the Chairman's discretion and/or his department's use prior to reaching an "overage" point. When departmental distributions have been satisfied, a balance, or "overage" may occur. This is allocated: 60% retained by department, 30% to the Dean's Fund, 10% to a School reserve fund. A great amount of latitude exists in the expenditure of departmentally retained funds as long as University procedures and policies are followed.

Practice Plan

Income Flow Diagram #4 (Type B)

(Public Medical School, Northeast)



Practice Plan

Income Flow Diagram #5 (Type B)

(Public Medical School, West)

The Plan at this large public university medical school exists as a federation of sixteen specialty groups, each structured as a partnership and as a legal entity separate from the University. Institutional policy restricts members of the full-time, salaried faculty to medical practice which is incidental to the discharge of their primary teaching and research responsibilities; they are not permitted independent private medical school practice. All patient-related income flows through the Plan; however, physicians may retain honoraria, royalties, etc.

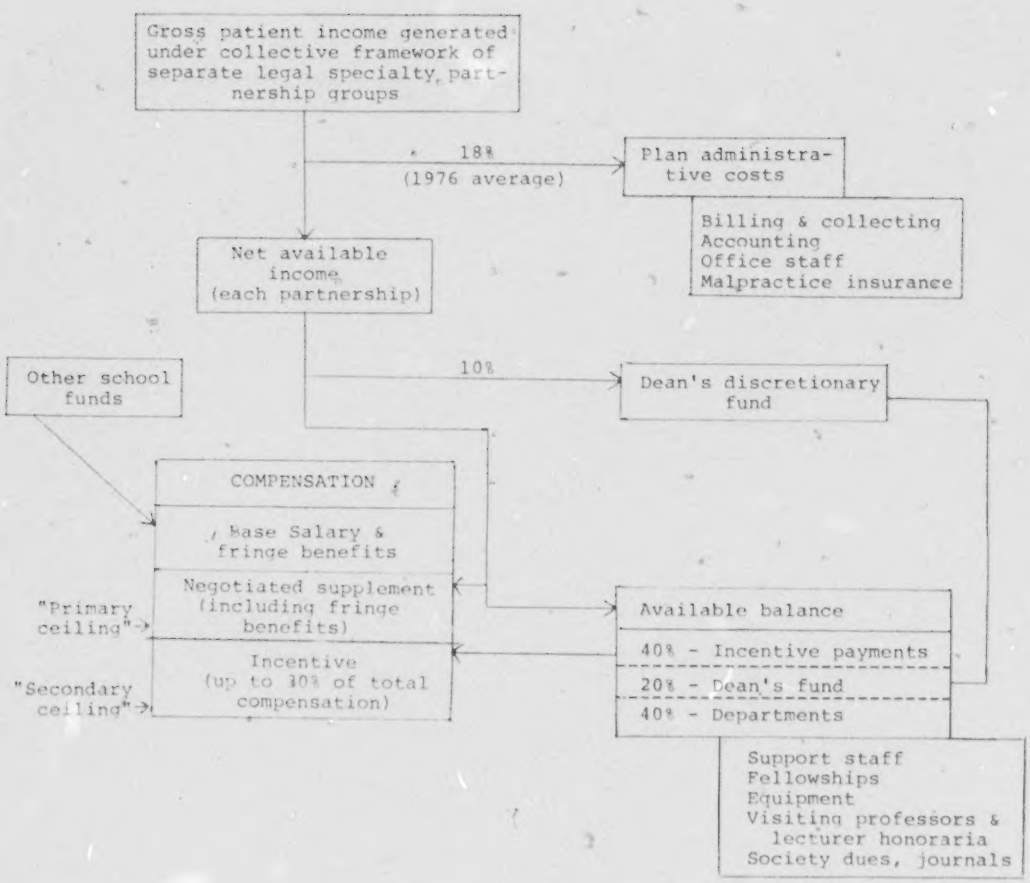
All practicing full-time faculty have identified in their annually negotiated employment contract a base institutional guaranteed salary component which may be supplemented up to a "primary ceiling" from the fees of patients seen by him. A "secondary ceiling" is allowed under an incentive arrangement which is influenced by the respective physician's productivity in the specialty group's practice. This is limited to 30% of total compensation. A basic concept dominates this Plan: "Those who earn the dollars, essentially keep them".

Management and related services, including all accounting, billing and collection functions, are provided by a central facility. Associated costs are allocated or assessed to the partnership and partners as a monthly service fee. After these costs are met, the Dean receives 10% of the balance for discretionary use. The available net is then used first to meet the negotiated supplement (up to "primary ceiling") and then is distributed in the following manner: 40% to support incentive payments (to "secondary ceiling"), 40% retained by the earning departmental group to be used broadly (except for further faculty salary supplementation), and 20% to the Dean for his discretionary use.

Practice Plan

Income Flow Diagram #5 (Type B)

(Public Medical School, West)



Practice Plan

Income Flow Diagram #6 (Type C)

(Private Medical School, Northeast)

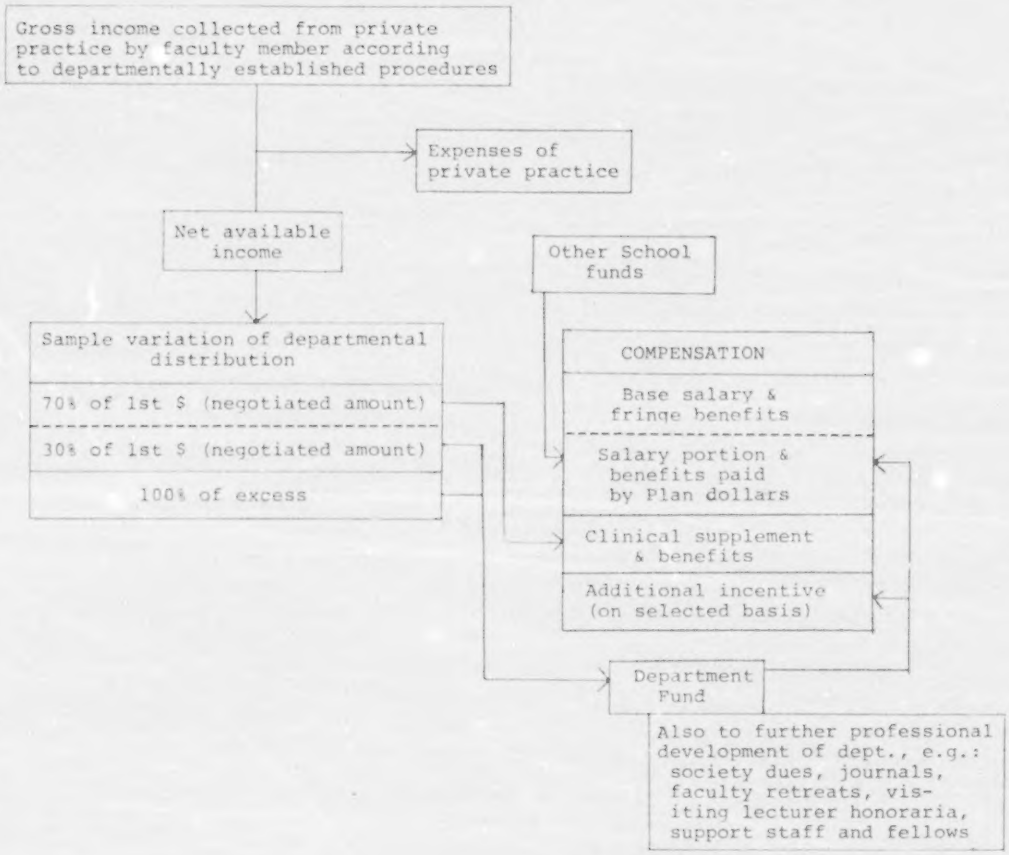
A fully institutional Plan imposing the same administra-procedures across all clinical departments does not exist at this large private university medical school. Rather, each clinical department, subject to the Dean's review, sets the policies for its faculty in the conduct of their practice and billing and collection. Some departments bill and collect centrally, while others allow the procedures to be done at a lower level, i.e. individual or groups. Distribution formulae also vary among the departments. All full-time faculty who practice must abide by the individual department's ground-rules.

The expenses of private practice, as the accompanying example shows, constitute the first demand on the individual's gross collections. This and subsequent distributions are set forth in an annual employment agreement between the faculty member and his Department Chairman with authorization of the University's Board of Trustees. The individual is paid a base salary and accompanying benefits, generally from University resources including practice plan dollars. A clinical supplement is provided from net practice income. As illustrated, this is 70% of a negotiated amount. The remaining 30% is deposited in the respective Department Fund, used by the Department to further professional development. Additional incentive, or bonus, payments may be made to selected Department personnel. Royalties from publications and honoraria from lectures are not considered private practice income. The Dean's office does not receive any portion of the distribution.

Practice Plan

Income Flow Diagram #6 (Type C)

(Private Medical School, Northeast)


Gross income collected from private practice by faculty member according to departmentally established procedures
Expenses of private practice
Net available income
Other School funds
Sample variation of departmental distribution
70% of 1st $ (negotiated amount)
30% of 1st $ (negotiated amount)
100% of excess
COMPENSATION
Base salary & fringe benefits
Salary portion & benefits paid by Plan dollars
Clinical supplement & benefits
Additional incentive (on selected basis)
Department Fund
Also to further professional development of dept., e.g.: society dues, journals, faculty retreats, visiting lecturer honoraria, support staff and fellows

Practice Plan

Income Flow Diagram #7 (Type C)

(Public Medical School, South)

Although this Plan provides a set of written ground rules and a central locus for monitoring patient care activities, the individual practitioners retain the right to conduct solo, partnership, or corporate practice, responsible for their own billing and collecting. All full-time clinical faculty, however, must be members of the Plan. Because of the latitude in the nature of the practice permitted, it is conducted in a wide variety of facilities, both within the medical school and its affiliates, as well as outside that environment. The Plan at this institution operates within the framework of a nonprofit corporation whose purpose is to further academic endeavors at the University School of Medicine, including financial support for its programs, facilities, equipment, and personnel.

Billing and collection is conducted by the practice entity, i.e. individual, partnership. Each is responsible for reporting all patient-related income resulting from private practice and professional business deductions allowed by IRS, as well as individually deducted fringe benefits. This report, submitted annually, shall include appropriate portions of federal income tax returns.

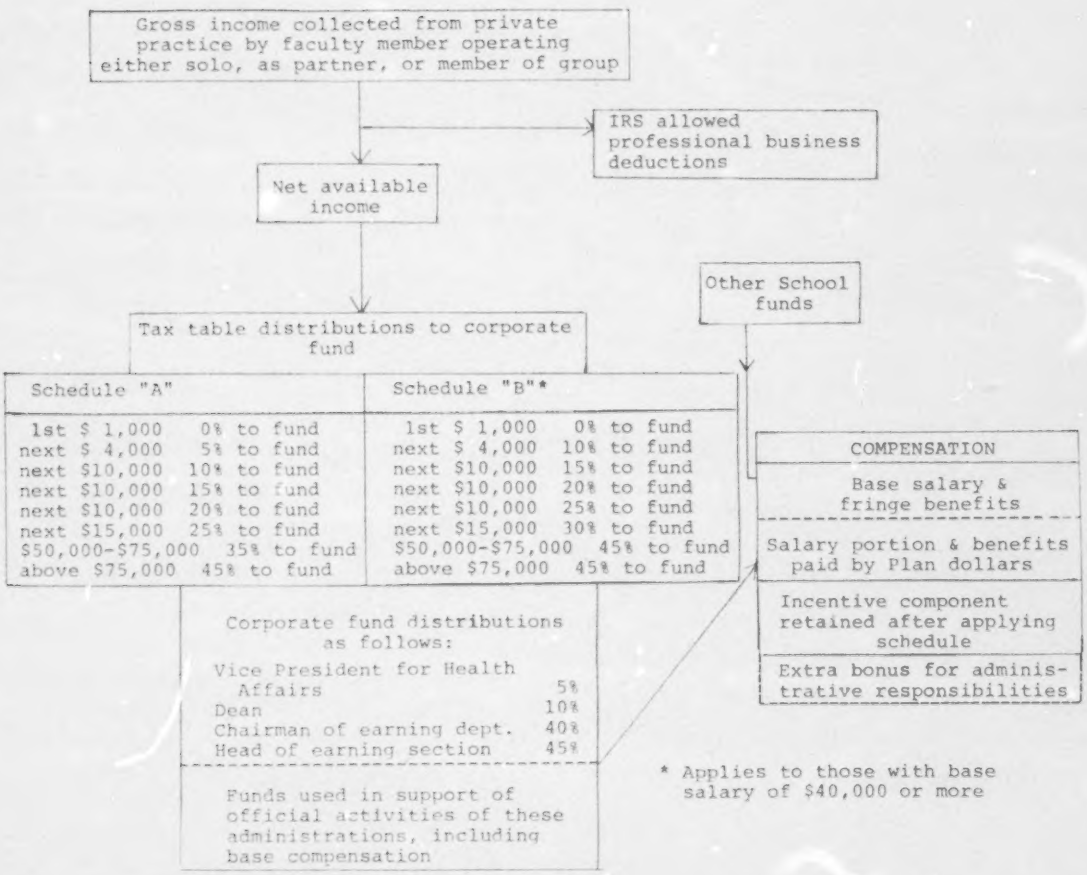
A Plan member's compensation is comprised of two components: 1) a base University salary, and 2) incentive supplement from private practice. The base salary is determined annually by the department chairman, the Dean and higher authorities, and subject to established minimums according to academic rank. Base salary support may derive from a mix of sources, including Plan revenue. It is generally understood that for new faculty, Plan funds are not to be used for more than 75% of the members' base salary after the first 24 months of employment, or 50% after the first 48 months of employment. Depending upon the amount of his base salary, the Plan member is assigned to one of two tax schedules under which he pays to the corporation from his net earnings a progressively higher amount as his earnings increase. In recognition of administrative responsibilities, section/department heads and other administrative officers who are full-time faculty members are permitted to exempt set amounts from the percentage apportionment on the tax schedule.

After applying the tax table, the amount distributed to the corporate fund is further apportioned to the Vice President for Health Affairs, the Dean, the Chairman of the earning department, and the head of the earning section.

Practice Plan

Income Flow Diagram #7 (Type C)

Public Medical School, South)


Gross income collected from private practice by faculty member operating either solo, as partner, or member of group
IRS allowed professional business deductions
Net available income
Other School funds
Tax table distributions to corporate fund
Schedule "A"
1st $ 1,000 0% to fund
next $ 4,000 5% to fund
next $10,000 10% to fund
next $10,000 15% to fund
next $10,000 20% to fund
next $15,000 25% to fund
$50,000-$75,000 35% to fund
above $75,000 45% to fund
Schedule "B"*
1st $ 1,000 0% to fund
next $ 4,000 10% to fund
next $10,000 15% to fund
next $10,000 20% to fund
next $10,000 25% to fund
next $15,000 30% to fund
$50,000-$75,000 45% to fund
above $75,000 45% to fund
COMPENSATION
Base salary & fringe benefits
Salary portion & benefits paid by Plan dollars
Incentive component retained after applying schedule
Extra bonus for administrative responsibilities
Corporate fund distributions as follows:
Vice President for Health Affairs 5%
Dean 10%
Chairman of earning dept. 40%
Head of earning section 45%
Funds used in support of official activities of these administrations, including base compensation
* Applies to those with base salary of $40,000 or more

Trends

The AAMC's annual nationwide collection of medical school financial data provides a basis for assessing the growth of practice plan income. In the 1956-57 institutional fiscal year, 21 of 85 existing medical schools reported $3.8 million in expenses paid from medical service funds; by 1960-61 this had grown to $12.8 million for 29 out of 87 schools.[4] For 1967-68, out of 89 operational medical schools, 54 reported $48.1 million in support from practice plan revenue.[5] By 1974-75, most U.S. medical schools had become quite dependent upon the income generated by practice plans to help defray their regular operating expenditures. During that year 76 schools out of 107 fully accredited institutions reported $303.0 million in support from this source.[6] (See Table 2).

Several conclusions can be drawn from the above data and from other information included in the cited references. First and most obvious is the explosive growth in reported income generated for the medical schools from practice plans. From 1956-57 to 1974-75 there has been an annual compound rate of increase of 27.5% over the eighteen years. Further, the proportion of support from practice plans to total unrestricted, or regular operating support, has grown over this period from 2.6% in 1956-57 to 20.3% in 1974-75.[7]

One further revealing observation is the incidence of medical schools reporting practice plan revenue. For 1956-57, less than 25% of the schools supplying financial information to the AMA/AAMC identified practice plan support. By 1974-75, however, over 70% of the reporting institutions indicated support from this source.

Such data actually understate plan-generated dollars since what is generally reported to the AMA/AAMC is income recorded in the medical schools' accounting records; to the extent that a practice plan operates outside the medical school and does not provide a full income flow through the school, the respective dollars may not be reflected. Nevertheless the above observations do support the conclusion that many more medical schools are able today to report, at least in part, income from practice plans and expenditures therefrom.

Beyond these financial trends, the character of practice plans has changed considerably over the past two decades. Two particular studies during this period addressed the nature of practice plans. Carroll's study (cited above)[8] described in some detail the faculty practice arrangements at ten public and nine private medical schools.

T A B L E 2

Growth of Expenditures from Medical Service Funds

| Year | No. of Operational Medical Schools | No. of Schools Reporting Medical Service Fund Expenditures | Aggregate Amount (Millions of dollars) |
|---|---|---|---|
| 1956-57 | 65 | 21 | 3.8 |
| 1960-61 | 87 | 29 | 12.8 |
| 1967-68 | 89 | 54 | 48.1 |
| 1974-75 | 107 | 76 | 303.0 |

Source: Annual AMA/AAMC LCME Questionnaire on Medical School Financing

His observations were the result of visits to the schools during the fall and winter of 1956-57. The schools were selected to provide both geographical coverage as well as representative organizational patterns. A second study, undertaken ten years later by Clyde T. Hardy, Jr. summarized the findings of a survey which produced data from 72 institutions.[3] Using both of these milestone studies in conjunction with the AAMC's latest review of practice plan characteristics, a number of striking trends can be observed.

First, as to the actual existence of what could be called a "plan", Carroll observed that all of his study institutions in 1956-57 "had rather definite policies and practices regarding the private medical service activities of faculty members. However, in most cases they were not spelled out and organized into a complete, precise, and co-ordinated plan".[9] Mr. Hardy ten years later and after the implementation of Medicare/Medicaid legislation, found that of 72 institutions responding to his survey, only 22 four-year schools reported having in operation a school-wide faculty group practice plan, although sixteen others were definitely planning to develop one.[10] The AAMC's most recent study has found that well over half of all operational medical schools have a documented and functional practice plan.

Twenty years ago as evidenced by Carroll's study, the part-time, volunteer, and geographic full-time (GFT) faculty appointment system, rather than the strict full-time (SFT) system, represented the predominant pattern among the schools' clinical departments. The traditional GFT definition held that faculty with this type of appointment were entitled to retain practice earnings (usually to an unlimited degree) in addition to a modest institutional guaranteed salary. Frequently such practice was permitted geographically remote from the medical school or its teaching hospital. The strict, or absolute full-time appointment scheme, on the other hand, in its original form was a system where salary was set, with all patient earnings billed and retained by a central agency. The straight salary was not effected by the amount of patient care or the collection generated therefrom. Carroll found that twelve of his study's nineteen institutions operated exclusively under GFT arrangements, two used both GFT and SFT systems, one used a hybrid GFT/SFT scheme, and four were under SFT plans.[11]

Although Hardy's survey in 1967 did not ask the schools to identify themselves as to the SFT/GFT pattern, by interpolation from the responses of the 22 schools with

existing plans, in the majority of cases the SFT arrangement predominated. It is a safe presumption that those schools without an identified plan probably operated under a GFT-type system.

The precise number of SFT and GFT clinical faculty members in U.S. medical schools over time is difficult to ascertain since classical definitions of these designations have given way to many hybrid appointment arrangements. Nevertheless, the present AAMC study of practice plans seems to point to a return to the GFT concept. What can be advanced from the current study is that individual compensation incentives, though often controlled, are much more prevalent in plans today. Concomitant with that observation is the fact that the total compensation of the full-time academic clinical practitioner is much more dependent on his/her patient care activity than in earlier years.

Significant changes have also occurred since mid-century as to the practice setting for those bound by an institutional practice plan. During the 1950's as the demand for more doctors and additional institutions to train them became more pronounced, the scarcity of medical facilities in which expanding clinical faculties could see their patients became more acute. The GFT, or remote-site, fee-retention system was the rule as long as the medical schools and their university hospitals lacked the facilities to meet the faculty's needs. The American Medical Association reported in 1959 that only 18.6% of all M.D. faculty had their only office in the university medical center.[12] The rest, many of whom were part-time and volunteer faculty, had private offices outside the medical center. Hardy's observations as to available facilities in 1967 for the 22 school-wide group practice plans were inconclusive. The AAMC's recent study, however, has revealed that facilities are usually provided by the universities for their clinical faculties. This may be at the university or affiliated hospitals or within discrete ambulatory clinics. Private practice is in fact prohibited outside the academic medical center by the vast majority of plans.

A large majority of the current practice arrangements require participation for full-time faculty practitioners as a condition of employment. Not so in 1956-57 when Carroll discovered that of the schools in his study using other than an SFT system, only three had vague references to obligatory plan participation.[1] On the other hand, Hardy found ten years later that twenty of the 22 institutions with school-wide practice plans included the total private practice of

all strict and geographic full-time faculty practitioners.[13] Currently, there is growing use of signed employment agreements between school and practicing faculty members to give legal force to plan obligations.

The administration of practice plans is far different today than ten or twenty years ago. This can be seen in the structure of the plan, the assignment of managerial responsibility, the methods of fee handling and controls.

Carroll's review in 1956-57 revealed a definite lack of structure and vague or non-existent statements of significant ground rules. In only one was a separate manager for the plan specifically indicated.[1] By 1967, according to Hardy, 22 out of 72 responding medical schools reported having a structured group practice plan -- fourteen under the auspices of the medical school and eight operated as separate organizations. Sixteen of the 22 schools reported they had a full-time administrator or business manager for their plan.[14] As disclosed above in the results section of this report, the AAMC has found that well over half of the plans recently reviewed have a discrete organizational structure with full-time managerial staff.

Fee handling, i.e. billing and collecting of the charges for services to patients under a practice plan, is in most instances today a centralized function of the plan, whether a part of the medical school or center, or a separate organization. In some cases, however, it is centralized at the departmental level. Sometimes the function has been contracted out to a service bureau. Carroll found that only ten of the nineteen schools he reviewed had any "occasion to handle patient revenue except as a service to faculty members"[15] - and these were essentially instances where the SFT arrangement was dominant. Hardy discovered that fourteen of the 22 institutions with school-wide plans had separate centralized business offices for handling professional billing and collecting; in six institutions the hospital business office managed this function; and in two instances the medical school business office assumed the responsibility.[3]

Upon reviewing the nature of practice plans as described over the twenty-year period by Carroll, Hardy and the AAMC in its current study, there is one additional plan characteristic which has changed markedly - method of control. The ideal, whether understood orally or established in writing, has been that the private practice of each full-time clinical faculty member should not be so extensive as to impinge upon other academic responsibilities. Carroll found that one prominent means of

presumed control was a stated time restriction. Of the GFT arrangements he described, six had specified time limits for private practice, such as two half-days a week.[16] Carroll further observed that the American Medical Association was on record as favoring time as opposed to earnings controls over geographic, or part-time paid medical school faculty presumably so as not to violate traditional fee and payment patterns.[17] Hardy remarked that time ceilings could be useful in achieving a proper balance between practice and other academic obligations, but failed to determine how many schools used this device. He did note, however, that sixteen of the 22 schoolwide plans employed an earnings ceiling.[18] It is the contention of the authors that time ceilings are all but impossible to enforce with any precision. As the AAMC's current study has determined, earnings restrictions are the dominant control modality.

As can be seen from the above discussion, a number of trends in practice plan characteristics and financing are conspicuous when comparing the AAMC's latest findings with earlier studies undertaken over the past two decades. However, because of the "pendulum movement" of some of the characteristics, e.g. a fluctuation from GFT to SFT and back to GFT patterns, a projection of past trends into the future is risky. Since patient care will remain a vital function of most full-time clinical faculty members, however, one can safely conclude that written plans will be implemented for most schools, in order to secure reimbursement for faculty professional service and in order to maintain a proper balance between service and the other academic functions.

## CONCLUSIONS

Since this report covers only the first year of a two-year study of medical practice plans, conclusions at this point are regarded as tentative. Certainly this is true as one examines the physiology of a practice plan, i.e. functional processes and how they work together. An in depth review of this aspect of practice plans is to be undertaken during the second year of the study. From the review of plan anatomy and some operational features during year one, however, the following tentative conclusions can be made.

First, the senior administrators of a large number of U.S. medical schools have recognized in recent years the need to bring the patient care activities of their clinical faculties into some control through a written plan. This follows in most institutions from a growing conviction that the medical school should have an acceptable program balance between service, teaching and research. The former should not dominate the latter two to their detriment. In the words of one dean whose school has recently implemented a medical practice plan, "When the faculty member carries out his teaching, research, administrative and patient care activities under one roof and central authority, he becomes in truth a full-time member of his particilar department and of the total school faculty." (Specific citation not given in order to protect this school's anonymity).

As a probable consequence of the development of practice plans there has been a movement away from dominance of part-time salaried and volunteer faculty in lieu of full-time faculty in the medical schools. Full-time faculty practitioners have been attracted to academic medicine as a result of liberalized, though organized and controlled, compensation arrangements with their institution. Many schools have been quite imiginative in establishing incentive devices into their practice plans so as to mitigate any tendency to stop seeing patients once an absolute earnings ceiling has been reached.

One positive result of the more liberal, incentive-driven plan, has been the attraction and retention of capable full-time clinical faculty practitioners in the medical schools. Because of this, and also as a result of the disappearance of ward services housing only clarity patient, the schools have been able to attract a wider variety of teaching patients to their clinical facilities. The referral of private patients to skilled and experienced clinical faculty is accepted practice today.

A second significant conclusion is apparent from this phase of the study of practice plans. Their management has congealed into distinct administrative units with separate managerial leadership, discrete budgets and individualized fee handling, reporting and control systems. Medical schools are becoming increasingly aware of the need from a practical standpoint to monitor and to utilize judiciously the very large resources generated by the plans. As traditional financial support, relied upon by the schools to help defray their operating costs, has diminished from some quarters, the awareness of plan revenue potential has grown. The seemingly fine line has to be recognized, however, between overdependence and the possible accusation of faculty exploitation, and neglect of plan revenue as a viable alternative to financial stringency.

FOOTNOTES

[1] Carroll, A.J., A Study of Medical College Costs. Evanston, Illinois: Association of American Medical Colleges, 1958.

[2] Deitrick, John E., M.D. and Robert C. Berson, M.D., Medical Schools in the United States at Mid-Century. Evanston, Illinois: Association of American Medical Colleges, 1953.

[3] Hardy, Clyde T., Jr., "Group Practice by Medical School Faculty", The Journal of Medical Education, Vol. 43, No. 8, August, 1968.

[4] "Medical Education in the United States, 1962-1963", The Journal of the American Medical Association, Vol. 186, November 16, 1963, p. 145.

[5] "Medical Education in the United States, 1968-1969", The Journal of the American Medical Association, Vol. 210, No. 8, November 24, 1969, p. 1486.

[6] "Medical Education in the United States, 1975-1976", The Journal of the American Medical Association, Vol. 236, No. 26, December 27, 1976, p. 2967.

[7] "Medical Education in the United States, 1962-1963", The Journal of the American Medical Association, Vol. 186, November 16, 1963, p. 145; "Medical Education in the United States, 1975-1976", The Journal of the American Medical Association, Vol. 236, No. 26, December 27, 1976, p. 2970.

[8] A.J. Carroll, op. cit., pp. 1-2.

[9] Ibid., p. 121.

[10] Clyde Hardy, Jr., op. cit., p. 907.

[11] A.J. Carroll, op. cit., pp. 121-134. See also "Medical Education in the United States and Canada, 1958-1959", The Journal of the American Medical Association, Vol. 171, No. 11, November 14, 1959, pp. 1531-32.

[12] "Medical Education in the United States and Canada, 1958-59", The Journal of the American Medical Association, Vol. 171, No. 11, November 14, 1959, p. 1532.

FOOTNOTES (cont'd)

[13] Clyde Hardy, Jr., op. cit., p. 907.

[14] Ibid., p. 908.

[15] A.J. Carroll, op. cit., p. 58.

[16] A.J. Carroll, op. cit., pp. 121-134.

[17] Ibid., pp. 119-120.

[18] Clyde Hardy, Jr., op. cit., pp. 909-910.

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# A P P E N D I C E S

Appendix A - Checklist-Institutional Plan(s) for Medical Practice, 1976 (working form)

Appendix B - Medical Practice Plan Profile Matrix, 1976 (working form)

Appendix C - Sample letter and form to medical school dean requesting authorization to use data

# A P P E N D I X  A

Checklist
Institutional Plan(s)
for
Medical Practice
1976

October 1976

Organization, 1976
Medical Practice Practice Plans

_____
Respondent

_____
Telephone

Organization

A. Does your institution have any organized practice plan* that benefits the school of medicine?

1) ___No

2) ___Yes

B. Which type of organization describes the overall plan currently in effect?

1) ___Fully institutional* and encompassing all academic departments

2) ___Separately incorporated as described below:

3) ___non-profit corporation

4) ___corporation for profit

5) ___foundation

6) ___partnership

7) ___other:

_____

_____
(specify)

8) ___Varies by academic department and/or medical specialty

9) ___Other - describe:

_____

_____

_____

*See Glossary

Organization, 1976
Medical Practice Plans

KEY

PC = Professional Corp.
Fnd = Foundation
Prtn = Partnership
Hosp = Hospital-based group

C. Describe the variation in practice plan organization by academic department:

1) Anatomy (include Cell Biology)

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

2) Biochemistry

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

3) Microbiology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

4) Pharmacology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

5) Physiology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

6) Other Basic Sciences

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

7) Anesthesiology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

8) Community Health (include Public Health)

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

9) Dermatology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

Organization, 1976
Medical Practice Plans

10) Family Practice

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

11) Medicine

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

12) Neurology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

13) Obstetrics-Gynecology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

14) Ophthalmology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

15) Otolaryngology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

16) Pathology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

17) Pediatrics

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

18) Physical Medicine & Rehab.

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

19) Preventive Medicine

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

20) Psychiatry

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

21) Radiology (include Nuclear Medicine)

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

22) General Surgery

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

23) Neurosurgery

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

24) Orthopedic Surgery

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

25) Plastic Surgery

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

26) Thoracic & Cardiovascular Surgery

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

27) Urology

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

28) Other Clinical Sciences

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

_____

0 PC 0 Fnd 0 Prtn 0 Hosp 0 Other 0 None

Organization, 1976
Medical Practice Plans (con't)

D. When was the inception of a fully institutional practice plan?

1) _____ _____
(month) (year)

E. When was the last major revision to this practice plan?*

1) _____ _____
(month) (year)

*See Glossary

Membership, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Membership

A. Is there more than one category of plan membership?

1) ___No

2) ___Yes

3) ___Full*

4) ___Other:

_____

_____

_____
(specify)

B. What are the qualifications for Full membership* in this practice plan?

1) ___NONE, completely voluntary (includes departmental variations)

2) ___ELECTIVE, for Full-Time faculty: _____%potential

_____%actual

3) ___SFT, Basic Sciences

4) ___GFT, Basic Sciences

5) ___SFT, Clinical Sciences

6) ___GFT, Clinical Sciences

7) ___Other:

_____

_____
(specify)

*See Glossary

Membership, 1976
Medical Practice Plans (con't)

8) _____ELECTIVE for Part-Time faculty: _____%potential

_____%actual

9) _____ELECTIVE for Volunteer faculty: _____%potential

_____%actual

10) _____REQUIRED for Full-Time faculty

11) ____SFT, Basic Sciences

12) ____GFT, Basic Sciences

13) ____SFT, Clinical Sciences

14) ____GFT, Clinical Sciences

15) ____Other:

_____

_____
(specify)

C. What are the qualifications for less than full membership in this practice plan?

1) _____Physician practice

2) ____Location (teaching base)

3) ____Volume earnings (minimum)

4) _____ Individual employment contract

5) _____ Other - describe:

_____

_____

_____

Governance, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Governance

A. Who establishes the general policies* for the Practice Plan?

1) ___Board of Regents

2) ___University Board of Trustees

3) ___Medical School Board of Trustees

4) ___University Hospital(s) Board of Trustees

5) ___Joint Committee of Boards

_____

_____
(specify name and composition)

6) ___Dean

7) ___Plan Governing Body

8) ___Executive Committee of Plan Governing Body

9) ___Plan Advisory Committee

10) ___Plan Membership

11) ___Other:

_____

_____

*See Glossary

B. How is the Chairperson of the Plan Governing Body selected?

1) ___Elected by _____ (specify)

2) ___Appointed by _____ (specify)

3) ___Automatic by virtue of position as _____ (specify)

4) ___Other: _____

_____ (specify)

C. Describe the composition of the governing body:

1) ___Automatic membership by virtue of position:

_____

_____

_____

_____

_____

_____

_____

_____

2) ___Elected members:

_____

_____

_____

_____

_____

_____

_____

_____

D. Are the basic science faculty represented on the governing body of the practice plan?

1) ___No

2) ___Yes

If Yes, what is the formula for representation:

_____

_____

E. Is EACH clinical science department represented on the governing body of the practice plan?

1) ___No

2) ___Yes

If No, what is the formula for representation:

_____

_____

F. How are votes apportioned to the General Membership?

_____

_____

_____

_____

G. Does the practice plan include a set of by-laws?*

1) ___No

2) ___Yes

Administration, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Administration

A. Who is responsible for the day-to-day operation of the Practice Plan?

1) ___Full-time plan manager: _____
(name)

2) ___Staff member of medical school administration

3) ___Staff member of teaching hospital administration

4) ___Department or section head

5) ___Other:

_____
(specify)

B. To whom does this person directly report?

1) ___Plan Governing Body

2) ___Medical Director of Plan

3) ___Dean, Medical School

4) ___Administrator, Hospital(s)

5) ___Other:

_____
(specify)

C. Does the Plan have a Medical Director?

1) ___No

2) ___Yes

If Yes, by whom is that person appointed?

1) ___Plan Governing Body

2) ___Dean, Medical School

3) ___Administrator, Hospital

4) ___Other:

_____
(specify)

D. What additional mechanisms exist within the institutional environment for monitoring faculty practice activities?

1) ___Employment agreements

2) ___Central billing

3) ___Central fee collection

4) ___Audited financial statements (includes IRS returns)

5) ___Other:

_____

_____
(specify)

Practice Setting, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Practice Setting

A. Site for provision of inpatient and ambulatory patient services under practice plan guidelines?

1) ___Office within medical school and/or affiliated hospital

2) ___Office within school-owned medical building

3) ___Office within hospital-owned medical building

4) ___Office in a separate clinical facility independent of the medical school and its owned or affiliated hospital(s)

5) ___Physician-owned

6) ___Other

7) ___Hospital in-patient

8) ___Hospital out-patient

9) ___Ambulatory Clinics

10) ___Emergency Services

11) ___Other - describe:

_____

_____

B. Which expenditures for facilities and services are made directly or indirectly by the Plan(s)?

1) ___Examining rooms

2) ___Offices

3) ___Reception rooms

4) ___Furniture and equipment

5) ___Patient scheduling service

6) ___Medical records service

7) ___Patient billing service

8) ___Fee collection service

9) ___Nurse practitioners service

10) ___Physician assistants service

11) ___Laboratory service

12) ___Radiology service

13) ___Telephone service

14) ___Custodial service

15) ___Mailing service

16) ___Laundry service

17) ___Medical and surgical supplies service

18) ___Other - describe: _____

C. Which patient types are included within the Plan purview?

1) ___Source

2) ___Referrals

3) ___Other

4) ___Scene

5) ___In-patient

6) ___Out-patient

7) ___Reimbursement

8) ___% Indigent (without ability to pay)

9) ___% Insured

10) ___% Self-Pay

11) ___% Other: _____
(specify)

Practice setting, 1976
Medical Practice Plans (con't)

D. Are any patient-related income generating activites by Plan participants excluded from the purview of the Plan?

1) ___No

2) ___Yes

If Yes, describe the exceptions:

_____

_____

_____

Fees, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Fees

A. Who determines the schedule of fees for service under the practice plan guidelines?

1) ___Departments, divisions or services

2) ___Individual physicians

3) ___Plan membership

4) ___Governing body for the plan

5) ___Special Plan Committee

6) ___Other:

_____
(specify)

B. Is the billing centralized?

1) ___No

2) ___Yes

If Yes, who renders the bill on behalf of the physician providing service:

1) ___Plan Billing Office

2) ___Incorporated separately

3) ___Non-incorporated

4) ___Department

5) ___Service bureau:_____
(name)

6) ___Medical school

7) ___Hospital

8) ___Other:_____
(specify)

Fees, 1976
Medical Practice Plans (con't)

C. Is there a one bill system including professional and hospital service charges for ambulatory patients?

1) ___No

2) ___Yes

D. Do you always bill 100 percent of the fee schedule for professional services?

1) ___No

2) ___Yes

If No, explain:

_____

_____

_____

_____

E. How many patient statements are sent by the Plan participants monthly?

1) _____
(average)

F. What is the normal annual rate of collection on gross billings before adjustments for discounts and fee waivers?

1) ____%

G. What is the normal annual rate of collection after adjustments for discounts and fee waivers?

1) ___%

H. Can the sources of direct payment for patient service be identified?

1) ___No

2) ___Yes

Fees, 1976
Medical Practice Plans (con't)

If Yes, what percent of annual collections do the following sources represent:

1) ___% Blue Shield

2) ___% current rate of collection (net)

3) ___% Blue Cross

4) ___% current rate of collection (net)

5) ___% Medicare

6) ___% current rate of collection (net)

7) ___% Medicaid

8) ___% current rate of collection (net)

9) ___% Self pay

10) ___% current rate of collection (net)

11) ___% Other insurance

12) ___% current rate of collection (net)

13) ___% Unknown

I. Are collections credited to individual accounts of the faculty physicians rendering services?

1) ___No

2) ___Yes

J. What other fees or revenues must be turned over to the Plan?

1) ___None

2) ___Consulting fees (External activities)

3) ___Academic (Education-related)

4) ___Medical (Patient care-related)

Fees, 1976

Medical Practice Plans (cont'd)

5) ___Honoraria

6) ___Royalties

7) ___Other:

_____
(specify)

K. Has the Plan been reviewed and approved by IRS?

1) ___No

2) ___Yes

If Yes, when was the most recent review?

1) _____
(year)

L. Who collects the professional fees?

1) ___Individual physicians

2) ___Plan

3) ___Incorporated separately

4) ___Non-incorporated

5) ___Department

6) ___Service bureau: _____
(name)

7) ___Medical school

8) ___Hospital

9) ___Other:

_____
(specify)

Fees, 1976
Medical Practice Plans (cont'd)

M. Who disburses professional fees?

1) ___Individual physicians

2) ___Plan

3) ___Incorporated

4) ___Non-incorporated

5) ___Department

6) ___Service bureau:_____
(name)

7) ___Medical school

8) ___Hospital

9) ___Other

_____
(specify)

N. What method is used to pay for business services related to billing, collecting and managing professional fees?

1) ___Cost reimbursements

2) ___Service charge

3) ___% Fixed

4) ___Billings

5) ___Collection

6) ___% Variable with ceiling

7) ___Billings

8) ___Collection

Compensation, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Compensation

A. Is there a direct relationship between faculty utilization (% time spent in major areas of activity) and sources of compensation?

1) ___No

2) ___Yes

If Yes, what is the mechanism for relating faculty output to sources of compensation?

3) ___Activity analysis

4) ___Prospective

5) ___Retrospective

6) ___Effort analysis

7) ___Prospective

8) ___Retrospective

9) ___Program cost center identification

10) ___Other:

_____
(specify)

B. Do Plan participants receive an employment agreement upon appointment?

1) ___No

2) ___Yes

If No, what means of agreement is utilized?

_____

_____

_____

C. Is there more than one component of compensation provided for in faculty employment agreements?

1) ___No

2) ___Yes

If Yes, which components of compensation are affected by the level of medical practice activity?

1) ___Base

2) ___Amount

3) ___Proportion

4) ___Supplement

5) ___Amount

6) ___Proportion

7) ___Incentive

8) ___Amount

9) ___Proportion

10) ___Progressively taxed

11) ___Unlimited

12) ___Other:

_____
(specify)

D. Does the institution (medical school or university) specify salary ranges for full-time faculty positions held by Plan participants?

1) ___No

2) ___Yes,

3) ___Base salary

4) ___Total salary

E. Is there explicit recognition of variation in salary ranges for different medical specialties?

1) ___No

2) ___Yes

F. Which fringe benefits are institutionally provided to practice plan participants?

1) ___Disability insurance

2) ___Group health insurance

3) ___Major medical insurance

4) ___Life insurance

5) ___General liability insurance

6) ___Retirement

7) ___Tax sheltered annuity

8) ___Deferred compensation plan

9) ___Other:

_____
(specify)

G. Are any institutionally provided fringe benefits supplemented by the practice plan?

1) ___No

2) ___Yes

If Yes, which fringe benefits are supplemented:

1) ___Disability insurance

2) ___Group health insurance

3) ___Major medical insurance

4) ___Life insurance

5) ____General liability insurance

6) ____Retirement

7) ____Tax sheltered annuity

8) ____Deferred compensation plan

9) ____Other:

_____
(specify)

H. Does the Plan provide specific fringe benefits not provided by the institution?

1) ____No

2) ____Yes

If Yes, which benefits are made available to participants?

1) ____Disability insurance

2) ____Group health insurance

3) ____Major medical insurance

4) ____Life insurance

5) ____General liability

6) ____Retirement

7) ____Tax sheltered annuity

8) ____Deferred compensation plan

9) ____Other:

_____
(specify)

I. What is the source of malpractice insurance coverage for Plan participants?

1) ___University policy

2) ___Medical school policy

3) ___Hospital policy

4) ___Practice Plan policy

5) ___Departmental policy

6) ___Individual/Personal policy

7) ___Other: _____
(specify)

J. Who pays the premiums for malpractice insurance for Plan participants?

1) ___University

2) ___Medical school

3) ___Hospital

4) ___Practice Plan

5) ___Department

6) ___Individual

7) ___Other: _____

_____
(specify)

K. Has your medical school considered or decided to self insure for malpractice liability?

1) ___No

2) ___Yes

If Yes, self insurance has been

1) ___Under consideration

2) ___Implemented in _____
(year)

Income Distribution, 1976
Medical Practices Plan

_____
Respondent

_____
Telephone

Income Distribution

A. Indicate the distribution points for practice plan revenue by percentage allocation:

| Gross | Residual 1 | Residual 2 | |
|---|---|---|---|
| ____ | ____ | ____ | Plan operation |
| ____ | ____ | ____ | Physician compensation |
| ____ | ____ | ____ | Group (department) |
| ____ | ____ | ____ | Research and development by dept. |
| ____ | ____ | ____ | Medical school (general funds) |
| ____ | ____ | ____ | Medical center |
| ____ | ____ | ____ | University |
| ____ | ____ | ____ | Academic enrichment (dean) |
| ____ | ____ | ____ | Research and development |
| ____ | ____ | ____ | Plan trust |
| ____ | ____ | ____ | Other: _____ (specify) |

B. Do the Practice plan guidelines include a provision for adjustment in the percentage of income distributed to various points?

1) ___No

2) ___Yes

If Yes, describe the basis on which the distribution scheme could be renegotiated:

_____

_____

_____

Income Distribution
Medical Practice Plans (con't)

C. What mechanisms exist for limiting patient care activity?

1) ___None

2) ___Income ceilings - describe:

_____

_____

3) ___Time limitation - describe:

_____

_____

4) ___Limit on the number of private patients

5) ___Other:

_____
(specify)

D. Does the Plan restrict the purposes for which expenditures can be made from Plan income?

1) ___No

2) ___Yes

If Yes, which expenditures, exclusive of salary support, can be authorized by the Plan:

1) ___House Staff support

2) ___Medical reference service

3) ___Medical illustrations

4) ___Fellowships

5) ___Licenses

6) ___Permits (narcotics, etc.)

7) ___Continuing education (includes professional society dues, journals, travel, etc.)

8) ___Faculty retreats

9) ___Visiting professor and lecturer honoraria

Income Distribution
Medical Practice Plans (con't)

10) ___Equipment

11) ___Support personnel

12) ___Other:

_____
(specify)

E. Expenditures usually approved by departmental authority are as follows:

1) ___House Staff support

2) ___Medical reference service

3) ___Medical illustrations

4) ___Fellowships

5) ___Licenses

6) ___Permits ( narcotics, etc.)

7) ___Continuing education (includes professional society dues, journals, travel, etc.)

8) ___Faculty retreats

9) ___Visiting professor and lecturer honoraria

10) ___Equipment

11) ___Support personnel

12) ___Other:

_____
(specify)

Objectives, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Objectives

A. Which of the following objectives were finally adopted at the time of plan ratification or amendment?

1) ___Attract and retain capable medical educators

2) ___Acknowledge the social responsibility for providing high quality and accessible patient service

3) ___Contribute to the financial stability of the medical school

4) ___Contribute to the financial stability of the affiliated hospital(s)

5) ___Develop a more rational use of health resources in the community

6) ___Improve efficiency of business services

7) ___Increase physician productivity

8) ___Maximize opportunities for third-party reimbursement

9) ___Relates patient care to the education and training program of the institution

10) ___Other: _____
(specify)

Implementation, 1976
Medical Practice Plans

_____
Respondent

_____
Telephone

Implementation

A. How is the implementation of plan regulations monitored by the institution?

1) ___Budget development

2) ___Salary determination

3) ___Plan administration

4) ___Financial audits

5) ___Other:

_____
(specify)

# A P P E N D I X  B

Medical Practice Plan
Profile Matrix, 1976
(working form)

APPENDIX B

MEDICAL PRACTICE PLAN
PROFILE MATRIX
1976

## ORGANIZATION

| Institutional Plan(s)* | | | Plan Structure | | | | | Plan Age | |
|---|---|---|---|---|---|---|---|---|---|
| None | Single | Multiple | Fully Institutional* | | Separately Incorporated | Departmental Variations | Other | Inception Date | Date of Last Major Revision* |
| | | | Med. Sch. | Hospital | | | | Month Year | Month Year |

## MEMBERSHIP

| Types | | Qualifications - Full Membership* | | | | | | | Qualifications - Other Membership Types | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Full | Other | Varies by Dept. | Elective | | | Required | | Other | Varies by Dept. | Elective | | | Required | | Other |
| | | | FT %* | PT | Vol. | FT | PT | | | FT %* | PT | Vol. | FT | PT | |
| | | | | | | | | | | | | | | | |

## GOVERNANCE

| Governing Body Composition | | | | | | | | | | | | Method of Selection Chairperson of Governing Body | | | Existence of Plan By-Laws* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| None | Elected | | | | | Automatic* | | | | | | Elected | Appointed | Automatic* | |
| | Basic Sci. | | Clinical Sci. | | Other | Basic Sci. | | Clinical Sci. | | Dean | Other | | | | |
| | Each | Some | Each | Some | | Each | Some | Each | Some | | | | | | |
| | | | | | | | | | | | | | | | |

* See Glossary

Institution

MEDICAL PRACTICE PLAN
PROFILE MATRIX
1976

## ADMINISTRATION

| Operational Responsibility | | | | | Plan Manager is Responsible to: | | | | | Mechanisms for Monitoring Faculty Practice Activities | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Full-Time Plan Manager | Admin. Staff* | | Dept. or Sec. Head | Other | Plan Governing Board | Med. Dir. | Dean Med.Sch. | Hosp. Admin. | Other | Employ. Agreements | Central Billing | Central Fee Collect. | Financial Statements Required | Other |
| | Med.Sch. | Hosp. | | | | | | | | | | | | |

## PRACTICE SETTING

| Sites for Provision of Services by Plan Participants | | | | | | | | | | | Patient Types | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Offices | | | | | | Clinical Facilities | | | | Other | Source | | Scene | | Reimbursement | | | |
| Med. Sch. | Hosp. | Medical Sch. | Building Hosp. | Building Other | Other | Hosp. Inpat. | Hosp. OPD | Ambulatory Clinics | Emer. Serv. | | Referrals | Other | In-Patient | Out-Patient | Indigent | Insured | Self-Pay | Other |
| | | | | | | | | | | | | | | | ___% | ___% | ___% | ___% |

*See Glossary

Institution

MEDICAL PRACTICE PLAN
PROFILE MATRIX
1976

## F E E S

### Fee Schedule Determination

| Departments, etc. | Physician | Plan Membership | Plan Governing Body | Plan Cmttee | Other | Plan | |
|---|---|---|---|---|---|---|---|
| | | | | | | Inc. | Non-Inc. |
| | | | | | | | |

### Centralized Billing Services

| Department | Service Bureau | Medical School | Hospital | Other |
|---|---|---|---|---|
| | | | | |

| One Bill System for Amulatory Patients | Always Bill 100% Fee Schedule | Average Number Monthly Statements | Collection Rate on Gross Billings | Identification by Source of Direct Payment for Patient Service | Other Income Turned Over to Plan | Plan Tax Status: |
|---|---|---|---|---|---|---|
| | | | ___% | | | IRS Review ___ (date)<br>IRS Approval ___ (date) |

### Collection of Professional Fees

| Physician | Plan | | Depart. | Service Bureau | Medical School | Hospital | Other |
|---|---|---|---|---|---|---|---|
| | Inc. | Non-Inc. | | | | | |
| | | | | | | | |

### Disbursement of Professional Fees

| Physician | Plan | | Depart. | Service Bureau | Medical School | Hospital | Other |
|---|---|---|---|---|---|---|---|
| | Inc. | Non-Inc. | | | | | |
| | | | | | | | |

Institution

MEDICAL PRACTICE PLAN
PROFILE MATRIX
1976

## COMPENSATION

| Direct Relationship Between Faculty Utilization and Sources of Compensation | Plan Participant - Receives Employment Agreement upon Appointment | Ranges Specified for Total Salary of Plan Participant | Incentive Component of Compensation |
|---|---|---|---|
| | | | |

## INSURANCE

| Disability | | | Group Health | | | Major Medical | | | Life | | | General Liability | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP | IPWPS | PP | IP | IPWPS | PP | IP | IPWPS | PP | IP | IPWPS | PP | IP | IPWPS | PP |
| | | | | | | | | | | | | | | |

## RETIREMENT

| Retirement Plan(s) | | | Tax Sheltered Annuity | | | Deferred Compensation | | |
|---|---|---|---|---|---|---|---|---|
| IP | IPWPS | PP | IP | IPWPS | PP | IP | IPWPS | PP |
| | | | | | | | | |

IP - Institutionally provided
IPWPS - Institutionaly provided with plan supplementation
PP - Plan provided

## MALPRACTICE LIABILITY COVERAGE

| Source of Policy | | | | | | | Premium Payment | | | | | | | Self-Insurance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| University | Medical School | Hospital | Practice Plan | Depart. | Individ. | Other | University | Medical School | Hospital | Practice Depart. | Individ. | Other | | Consider | Implement (year) |
| | | | | | | | | | | | | | | | |

Institution

# A P P E N D I X  C

Sample Letter and Form to
Medical School Dean Requesting
Authorization to Use Data

aamc association of american medical colleges

November 23, 1976

Dear Dean:

On October 4, 1976 a memorandum from AAMC President, John A.D. Cooper, requested your support for our current Study of Medical Practice Plans. This project signifies a long standing interest by medical school deans in practice plan organization and administration. To facilitate development of a mechanism for keeping our information current, AAMC staff has designed two documents on which they record plan descriptions.

A blank copy of a draft form of the profile matrix was sent to your attention with Dr. Cooper's memorandum #76-40. Attached for your review are copies of both the revised profile matrix and the checklist on which the profile is based. Each form shows information descriptive of the practice plan at your school. A glossary has been prepared by staff to assist in interpreting the terms used to describe practice plan characteristics and is also attached.

Details relating to the practice plan(s) at your institution have been obtained through personal contact with medical school staff, site visit observations and perusal of written plan descriptions. The composite profile derived from these sources is displayed on the matrix to which we have previously referred.

We are now seeking validation and approval of this profile matrix to satisfy two goals:

1) Our immediate and short-term goal is to include this concise description of your practice plan in the final study report to be distributed to all medical school deans as well as to the sponsor.



Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100
AAMC CENTENNIAL (1876-1976)

2) Our long-term goal is to establish a flexible system for exchanging practice plan information and encouraging open discussions of topical concerns.

Your willingness to be involved in each phase of this AAMC Study considerably improves our chances for future advancement toward our long-term goal.

Please indicate on the attached sheet your preference for type of participation in the AAMC Study of Medical Practice Plans. I will be available upon request to talk with you about our Study and your participation in it. Our project deadline (December 15) is fast approaching, and we need your response as quickly as possible.

Sincerely,

William C. Hilles
Associate Director
Division of Operational Studies

WCH
Attachments

DEAN'S PREFERENCE
MEDICAL PRACTICE PLAN
STUDY INCLUSION
1976

Please check your preference(s) for inclusion in the current AAMC Study:

1._____ Include the profile matrix for this institution in the final report of Phase I.

2._____ Do not identify by name.

3._____ Identification by name is permitted.

4._____ The profile matrix may be used by AAMC staff for analysis.

5._____ Do not include the profile matrix for this institution in the final report of Phase I.

_____ _____
Dean Date

_____ _____
Institution Telephone

Please return this sheet with an APPROVED copy of the completed profile matrix for your institution to:

Ms. Sharon K. Fagan
Staff Associate
Division of Operational Studies
Suite 200, No. 1 Dupont Circle, N.W.
Washington, D.C. 20036
202-466-4687

# ANNOTATED BIBLIOGRAPHY OF MEDICAL PRACTICE PLANS

SPECIAL REPORT

Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

U.S. Department of Health, Education, and Welfare
Public Health Service
Health Resources Administration
Bureau of Health Manpower
Contract No. 231-76-0011

JUNE 1976

CONTENTS

*FACULTY PRACTICE INCOME*.....1

*ORGANIZATION AND OPERATION OF INSTITUTIONALLY-RELATED GROUP PRACTICE*.....2

*CASE STUDIES OF INSTITUTIONALLY-RELATED GROUP PRACTICE*.....4

*SOCIOECONOMIC AND POLITICAL ISSUES*.....7

*Faculty Practice Income*

American Group Practice Association. Income Distribution: An Abstract and Analysis. Alexandria, Virginia: American Group Practice Association, 1974.

Traces the considerations in developing an income distribution plan for a group practice. Includes sample excerpts from clinic policies which directly pertain to methods for determining physician income.

Bromberg, J. Patient-Generated Medical School Income. (Datagrams) Journal of Medical Education, 49:201-5, 1974.

Summarizes and compares the operating income sources for four-year accredited medical schools with emphasis on patient-generated revenue. Discusses the growing significance of this source of support for regular operations of medical schools.

Harvey, J.D. An Institutional Approach in the Funding of Full-Time Clinical Faculty Salaries. Journal of Medical Education, 49:219-28, 1974.

Describes the funding of fixed salaries of strict full-time clinical faculty at an affiliated teaching hospital of Johns Hopkins University School of Medicine. Discusses the creation of an internal environment that is conducive to relating percentage of faculty effort expended with strict apportion of sources of faculty salary. Addresses the issue of third-party reimbursement for professional medical and surgical care by faculty in theory and in practice.

Anlyan, W.G. Discussion of Faculty Practice Income. Clinical Research, 21:917-18, December 1973.

Stresses the importance of balancing a delicate system for providing patient care, research and teaching. Addresses the need for responsible controls that are useful and supportive to a variety of participants in the system.

Maloney, J.V., Jr. Discussion of Faculty Practice Income. Clinical Research, 21:918-20, December 1973.

Challenges the medical education establishment to identify the parameters in the system, describe their interrelationships mathematically and select objectives. Suggests that manipulation of the parameters, using economic incentive, will move the system to assure the meeting of objectives.

Petersdorf, R.G. Faculty Practice Income - Implications for Faculty Morale and Performance. Clinical Research, 21:911-17, December 1973.

Debates the strengths and weaknesses of two major types of compensation arrangements for clinical faculty. Predicts the effect of each type on physician behavior relating to patient care activities.

Hardy, C.T. Look Who's Thriving on Fee-For-Service. Medical Economics, 48:120, November 22, 1971.

Analyzes the growth of schoolwide medical group practices in terms of income volume and distribution.

AAMC Division of Operational Studies. Medical Service Plan Income. (Datagrams) Journal of Medical Education, 45:375, 1970.

Displays aggregate volume of income derived from medical school faculty service activities. Shows the dollar proportion of income from that source expended for faculty salaries.

*Organization and Operation of Institutionally-Related Group Practice*

Springall, W.H. Group Practice in the University Teaching Environment. Hospital Administration, 16:44-58, Spring 1971.

Identifies the major considerations to be reviewed by a large university medical center inaugurating a plan for group practice organization. Proposes administrative mechanisms for improving patient care, the teaching environment and the institutional financial situation. Provides some insight into the problems of reorganization and the inhibition to change patterns of operation.

Wolf, G.A., Jr. Practice Plans in Medical Education. Paper Presented at Meeting of Midwest-Great Plains Region of the Association of American Medical Colleges January 12, 1970. (Unpublished)

Gives a conceptual and operational checklist for organizing an institutional practice plan. Stresses the virtue of fiscal and professional accountability by medical educators who deliver patient services.

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Sketches the broad types of practice plans in operation with emphasis on regulation of professional earnings.

Hardy, C.T. Institution-Related Group Practice: Best of Both Worlds? Hospital Physician, 5:75-76, 120, 122 passim, February 1969.

Compares the advantages and liabilities of physician practice in an institutional-related group. Presents a checklist of criteria for use in evaluating a group practice related to an institution.

AAMC Division of Operational Studies. Group Practice By Medical School Faculty. (Datagrams) Journal of Medical Education, 43:86-7, 1968.

Condenses the varying types of group practice plans into six major classes. Charts the growth of school-wide group practice plans from 1943 to 1965.

Hardy, C.T. Group Practice By Medical School Faculty. Journal of Medical Education, 43:907-11, 1968.

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Contains a collection of contributed papers each describing a form of group practice affiliated with or intrinsic to a medical school. Twenty individual cases are discussed.

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Focuses on the environmental impact on state medical schools formulating a plan for remuneration of clinical faculties. Identifies the general and special features contributing to the evolution of one particular plan.

Nelson, N.B. The Iowa College of Medicine Plan for Private Practice. in ibid., Pp. 488-92.

Emphasizes the formation of a voluntary practice plan designed and supported by the medical school faculty. Shows the fiscal program of the plan graphically in detail.

*Socioeconomic and Political Issues*

Carter, G.M., Chu, D.S.C., Koehler, J.E., and Williams, A.P. The Federal Government and Academic Medicine: The Effects of Federal Programs on Activities and Outputs. Report No. R-1814/1-HEW. Santa Monica: Rand Corporation (in press).

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Child, C.G., III. Medical Care and Medical Service Plans: Their Implications for Medical Education. In Report of the First Institute on Clinical Teaching: Report of the Sixth Teaching Institute. Gee, H.H., and Richmond, J.B. (Eds.). Journal of Medical Education, 34:35-46, October, Part 2, 1959.

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Shindell, S. Letter to the Editor. Journal of Medical Education, 34:695-8, 1959.

Suggests organization of medical school faculty on a group practice basis with a series of semi-independent but coordinated sub-units. Discusses the competing interests in our free enterprise system and the implications of self-imposed versus externally-imposed control of the medical profession.

AMA Council on Medical Service. Private Practice By Medical School Faculty Members. Chicago: American Medical Association, 1956.

Deals with the differences of opinion on the matter of private practice of medicine between the local profession and medical schools. Analyzes quantitatively the data collected on a special questionnaire jointly prepared by the Council on Medical Education and Hospitals, the Association of American Medical Colleges, the Council on Medical Service and the American Hospital Association. Expresses the views of medical school deans regarding institutional policies governing private practice by full-time medical school faculty. Examines suggestions by the practicing profession on an appropriate medical school system for governing private practice by full-time staff.